HEALTH CARE PROBLEMS AND CONCERNS OF PERSIAN GULF WAR VETERANS: THE RESPONSE OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE AND RELATED ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

NOVEMBER 16, 1993

Printed for the use of the Committee on Veterans' Affairs

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MATERIAL SUBMITTED FOR THE RECORD

HEALTH CARE PROBLEMS AND CONCERNS OF PERSIAN GULF WAR VETERANS: THE RESPONSE OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE AND RELATED ISSUES

TUESDAY, NOVEMBER 16, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Montgomery, Gutierrez, Kennedy, Long, Kreidler, Ridge, Bachus, and Quinn.

Also Present: Representatives Browder and Collins.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. The hearing will come to order.

On June 9, the Subcommittee on Oversight and Investigations conducted a nine-hour marathon hearing on the health care problems and concerns of Persian Gulf War veterans. From veterans and their loved ones, we learned that many who served are now chronically ill.

These heroes of the Persian Gulf War are shackled by a wide array of health problems and symptoms. They had been healthy and physically fit before their Gulf services. Now, they cannot resume the active and productive lives they led before serving in the Gulf.

These ongoing health problems were reemphasized last week when the full committee, at the request of Congressman Joe Kennedy, conducted a special hearing and received added testimony from more than a dozen individuals.

In June, we also learned veterans and active duty servicemen and women were not always receiving priority medical attention for their health problems. In some cases, veterans were reportedly told they would not receive care until they made a copayment. In other cases, repeated efforts to get help from their government produced only repeated failure. Some Gulf War veterans turned elsewhere for help. Others simply gave up.

Witnesses representing VA and DOD told the subcommittee some Gulf War veterans did have health problems, but a diagnosis had been elusive. More research was needed. Gulf veterans' health

problems were not a mystery to several private physicians who appeared before the subcommittee. But while they identified cause, diagnosis and treatment, their answers were not the same.

In the 5 months since the June hearing, what has been done and what has been learned about these health care problems? How have the VA and DOD responded and how have they worked together?

What research has been conducted and what new information has been gained? What treatment is being provided and is it successful?

What has been learned from the Gulf War Registry programs? Do we know what happened in the Gulf and the causes of these health care problems?

Has all the information which might be essential for effective treatment been provided?

These and many other related subjects are the issues before the subcommittee today.

I am very pleased at this point to recognize the distinguished chairman of the full committee, Sonny Montgomery.

Mr. MONTGOMERY. Thank you very much, Mr. Chairman. As you said in your statement, we need to get all of the information and all of the facts we can about chemical weapons that could have been used or not used in the Persian Gulf.

I commend you for having this hearing, and I commend you for starting on time.

Mr. EVANS. Following your leadership, Mr. Chairman.

The gentleman from New York.

OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman, and thank the chairman of the full committee, Mr. Montgomery, for reminding the three of us that we are on time.

Mr. Chairman, I appreciate more than any the work you have done on this issue, and look forward to hearing testimony this morning.

It seems that each and every week more information comes to light on this matter, and the important thing for all of us to recognize and to keep in the forefront of our minds is that we don't fool around and wait with this thing. Time is of the essence, and the sooner we get to it the better. I think all of us agree with that.

I will have an opening statement for the record, but I appreciate the time——

[The prepared statement of Congressman Quinn appears at p. 103.]

Mr. EVANS. It will be included in its entirety, and we salute you for being here at the beginning, as you are regularly.

Mr. QUINN. Thank you.

Mr. EVANS. The subcommittee's first witness today is Hellen Gelband, Senior Associate, Health Program, Office of Technology Assessment. She is accompanied by Maria Hewitt and Clyde Behney.

Hellen, your entire statement will be made part of the hearing record, without objection, and you may proceed when you are ready. If you care to summarize, you may do so.

STATEMENT OF HELLEN GELBAND, SENIOR ASSOCIATE, HEALTH PROGRAM, OFFICE OF TECHNOLOGY ASSESSMENT, ACCOMPANIED BY MARIA HEWITT, SENIOR ANALYST, HEALTH PROGRAM, AND CLYDE J. BEHNEY, ASSISTANT DIRECTOR, HEALTH, LIFE SCIENCES AND THE ENVIRONMENT

Ms. GELBAND. Thank you, Mr. Chairman, for the opportunity to participate in this hearing.

Public Law 102–585 charged the Director of OTA with assessing the potential utility of the DOD and VA Registries for "scientific study and assessment of the intermediate and long-term health consequences of military service in the Persian Gulf."

Our first report, issued 2 months ago, focused on the Department of Veterans Affairs Persian Gulf Veterans Health Registry, which is the examination program initiated by the VA for Persian Gulf veterans.

We also started to look at how the Defense Department is carrying out its mandate, developing a geographic information system linking troop locations with exposure to oil well fires.

When Congress directed the VA to create a Registry for health examinations of Gulf veterans, the greatest potential hazard appeared to be the smoke pouring from hundreds of oil wells that had been set on fire by the Iraqis. The Defense Department mandate also centered on assessing the risk to health posed by the fires.

Once completed, the DOD system may be used in various ways to consider possible health damage from oil fire smoke. DOD will be able to tell individual veterans about his or her level of exposure by using daily company locations and modeled estimates of air pollutant concentrations, although it will be difficult to explain just what those exposures mean in terms of the veteran's health. The DOD system also could be used to identify cohorts of individuals with relatively high and relatively low exposures to the oil fire pollutants should it be decided that it is necessary to do in depth studies.

The emphasis on oil fires as the exposure around which both DOD and VA conducted their activities, however, means that it will be much less useful for exploring other potential hazards. The limitations of DOD's and VA's mandated activities are worth noting.

The VA Registry can provide only descriptive information about the individuals who requested an examination either because they are sick or because they fear potential ill effects of their Gulf service. The hope is that the individuals who do come will serve as sentinels for health problems that might be emerging among Persian Gulf veterans more widely, but no valid conclusions about cause and effect can be made on the basis of the Registry population alone.

The task of deciding whether to pursue a possible health problem in a separate study will be the big challenge and one for which there is no set of rules to follow. The judgments of experts in medicine and epidemiology will have to be relied on and strong differences of opinion about what to do are guaranteed.

The DOD system will be used mainly for studying the effects of oil fires and possibly also for other geographic variables, but already there are concerns about inoculations, depleted uranium, vehicle paint, diesel fumes, and chemical warfare agents to name a

few, and these will benefit relatively little from DOD's Registry activity.

Whether or not these represent real threats, they must at least be acknowledged and considered for further evaluation and that work will have to proceed on an ad hoc basis in addition to the mandated Registry.

Decisions about whether epidemiologic studies should be undertaken will be made ultimately on the basis of expert opinion offered by the Institute of Medicine's Medical Follow-up Agency, and, of course, also by VA and DOD. But there is no neat formula for them to make those decisions.

The IOM's job could be made easier however, by making sure that they have an accurate historical record of troop activities in the Persian Gulf and that there is a clear idea of what information about possibly hazardous exposures exist in personnel and other military records. This information is not now easily available, as we found out when we were asking to get records of that sort.

OTA's report includes the following suggestions: (1) that specific changes be made in the Department of Veterans Affairs' examination protocol; (2) that coordination between DOD and VA be strengthened, perhaps by appointing a single advisory board to oversee both activities, which would be independent of VA and DOD and would include technical experts and veterans representatives; (3) that the Department of Defense assemble information about the Persian Gulf Conflict, including the specific activities of military units and the distribution of other potential exposures and experiences.

Next, that DOD and VA each catalog and describe other medical information available for Persian Gulf veterans from before, during and after their tours of duty, such as their intake examinations, blood samples that may have been stored and other medical examinations.

And finally, that VA and DOD standardize the terminology that they are using in their activities. We believe that that is relatively simple and should be happening now.

We are working on our second mandated report which will focus on DOD's Oil Fire Modeling Project. This includes the development of a geographic information system which comprises satellite mapping, atmospheric monitoring, modeling of contaminant concentrations, and health risk assessment, all being carried out currently in a pilot phase by the Army Environmental Hygiene Agency.

The Army expects to report on the pilot project at the end of the calendar year, and OTA's report is due in February. Those efforts will eventually incorporate troop location data being assembled by the U.S. Army and Joint Services Environmental Support Group. OTA will report on the technical merit of each major component and on how the system will work together.

A particular concern and one that requires coordinated effort between VA and DOD now is how information about individual risks will be communicated to veterans.

Thank you again for the opportunity to appear here, and we will be happy to answer any questions.

[The prepared statement of Ms. Gelband appears at p. 157.]

Mr. EVANS. Thank you very much.

Before asking members of this panel questions, I want to introduce some of the Members that have joined us, including the ranking minority member, Tom Ridge from Pennsylvania.

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. Thank you, Mr. Chairman. Let me thank you for your continuing interest and your leadership in this measure. I believe you initiated the first set of hearings on the Persian Gulf syndrome and the problems affecting our veterans in that area many, many months ago, and I applaud your leadership.

Last week, we heard some very compelling and collaborative testimony from Persian Gulf veterans, and I know that the Department of Defense and the Department of Veterans Affairs are concerned about medical causation. There is a great deal of work we need to do in order to determine whether or not some or all of these men and women are presently suffering as a result of their service.

But I have been a long-standing proponent of giving these men and women veterans anywhere the benefit of the doubt. And, as the doctors and the scientists scramble to determine medical causation and therefore service connection, it seems to me that there are enough of these men and women who experience this wide range of physical problems and they all have one thing in common. They didn't have these problems before they got to the Persian Gulf. Physical manifestations were evident either at the time of service or shortly thereafter.

Caring for our veterans is a continuing cost of our defense, and I certainly hope that the Department of Veterans Affairs will give these men and women the benefit of the doubt while the scientists determine medical causation down the road. I think it is absolutely imperative.

We heard testimony last week that some of these men and women are waiting in excess of a year for that initial examination.

So I applaud your continuing effort and pledge to work with you in whatever way possible to get them into these facilities for that initial examination, and give them the benefit of the doubt. They deserve to be treated. It is a continuing cost of defense, and not to do anything, in my judgment, would be literally turning our backs on them, and I don't think anybody in this committee wants to do that.

I thank you, Mr. Chairman.

Mr. EVANS. Thank you. I associate myself with your remarks and will be working with you to address these issues.

Let me introduce the number one point man in Congress, I believe, in terms of dealing with this entire issue. Glen Browder from Alabama.

Mr. BROWDER. Thank you, Mr. Chairman. We have got a lot of witnesses that we all want to hear from today. I have no remarks, other than to thank you for your leadership on this.

Mr. EVANS. Does the gentleman from Georgia have any opening statement?

OPENING STATEMENT OF HON. MAC COLLINS

Mr. COLLINS. Thank you, Mr. Chairman. I appreciate the opportunity of being allowed to participate this morning. I do have a statement I would like to submit for the record, and also permission to submit statements and letters on behalf of the 24th Naval Reserve Construction Battalion from Columbus, GA, they have sent up that they would like to have submitted for the record also.

[The prepared statement of Congressman Collins, with attachments, appears at p. 106.]

Mr. EVANS. Without objection, so ordered.

The gentleman from Illinois.

Mr. GUTIERREZ. Mr. Chairman, I am going to refrain from making any comment right now. I am going to wait for the witnesses from the State of Illinois and the City of Chicago at our hearing that you were so generous to conduct with me a couple of weekends ago to expound on this issue.

Thank you very much for calling this hearing.

Mr. EVANS. The gentleman from Massachusetts.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY II

Mr. KENNEDY. I am sorry I had to be a couple minutes late, Mr. Chairman, but I do appreciate the opportunity to give an opening statement this morning.

I want to thank you for holding this very, very important hearing and the impressive array of witnesses that you have been able to assemble. Chairman Evans, who is the chairman of this subcommittee, has done yeoman's work in trying to continue to pursue exactly what happened in the Persian Gulf and what potential exposures created the illnesses that we have heard so many individual soldiers indicate that they are facing.

Today marks the fifth hearing that this committee has held to investigate the health concerns of Persian Gulf veterans. Yet today the VA and DOD are not any closer to understanding the ailments of Persian Gulf veterans. Measurable progress has not been made. Today, even more questions remain to be answered by the Defense Department and the VA about possible causes and diagnoses and treatment of the serious illnesses experienced by thousands of soldiers.

Last week, the Pentagon acknowledged the Czechoslovakian Defense Ministry findings that chemical warfare and mustard gas agents were detected during the early phases of the Persian Gulf War. Yet despite repeated calls by the Congress, DOD's investigation has been cursory at best.

DOD maintains that there were no U.S. reports of detections and that there were no reported health effects in the field. This runs contrary to the accounts of many of our Persian Gulf troops.

At a special committee hearing last week we heard compelling testimony from veterans who believe that they were hit by chemical and biological warfare agents. We were assured by DOD that those cases would be investigated by today, but so far we have had no response back from the Pentagon. In fact, from the DOD briefings, it sounds like the Pentagon and our soldiers fought two different wars. There must be full and public disclosure of all infor-

mation about chemical and biological agents and all other possible exposures behind these ailments that might explain the sicknesses.

In light of recent concerns about biological and chemical warfare agents, I will commend VA Secretary Brown for taking swift steps to announce a pilot program for testing veterans who feel that they may have been exposed to these agents.

Last week's testimony from Persian Gulf veterans about their inability to get recognition and treatment for their health concerns demonstrated in human terms the many common threads of their experiences, not only a similarity of symptoms of their illnesses, but the pattern of inadequate response from the VA and DOD medical systems designed to provide for their care. They feel that the VA and DOD have turned a deaf ear to their concerns.

Government efforts have not been comprehensive or aggressive enough. While the VA and DOD ponder the next steps, our desperately ill Persian Gulf veterans struggle for answers amid deteriorating health and bankrupt savings.

The men and women who served our country in the Persian Gulf deserve resolution of their health concerns. VA and DOD must now convince them that their service to our country has not been forgotten by responding now.

Mr. Chairman, I thank you again for holding these hearings, and I very much look forward to the testimony of our witnesses today. Appreciate the time.

Mr. EVANS. Thank you very much.

Does the gentlewoman from Indiana have any opening remarks?

Ms. LONG. I have no opening statement.

Mr. EVANS. Ms. Gelband, we are going to be focusing today on the coordination between the Department of Defense and VA. We have had concerns about the Department of Defense not giving VA timely information, particularly about chemical attacks.

One of the issues that you suggest might be improved upon is supplementing existing coordination and cooperation with regards to the Registries. Could you elaborate a little bit more on that?

Ms. GELBAND. I think the most important recommendation that we made in that regard is to have a joint oversight committee that is not part of DOD or VA to help look at the big picture—what are the potential uses of all these various information collection systems and how can they be used best to help the veterans.

At the moment what we see is that VA and DOD are both very much concerned with carrying out their mandates and individually developing their systems, and in that they are making considerable progress, but there isn't focus on the bigger picture.

For instance, the potential chemical agent situation could be—an oversight committee, which would be better at deciding or helping decide where studies could be done and what exactly needs to be done at a given moment.

Mr. EVANS. The gentleman from Pennsylvania.

Mr. RIDGE. Are you satisfied with the protocol that the Department of Defense has established in collaboration with the VA to identify troop locations, to deal with troop movements, to take the history we have of the different SCUD missile attacks, location of the oil fires, bringing all of these things into consideration so that they are in a position to either affirm or deny some of the testi-

mony, or reject some of the testimony made by individual veterans with regard to their relationship to these different attacks and the impact on them and their personal health.

Ms. GELBAND. We haven't fully evaluated DOD's activities. That is our second report. But we have started to, and I think in terms of troop locations we are comfortable that that is proceeding apace and that the information that the environmental support group will need is available both in some computerized records and in paper records, and that that will be taken care of.

We also are confident that the position of the oil fires is fairly well known from satellite photographs and ground monitoring of the air. DOD also is carrying out modeling for periods when they had no on-the-ground monitoring, and that also is probably relatively secure.

I don't know that they have any plans to include the positions of SCUD missiles. That wasn't part of their mandate and I don't know whether they have that information.

Mr. RIDGE. Okay. Well, I appreciate that.

There was a gentleman who testified last week that based on his training and based on the device that they had in their area that would detect chemical or biological or bacteriological warfare, that shortly after what he thought was a SCUD missile attack, he felt a burning sensation of his skin, his eyes were watering, he had a bad taste in his mouth, and 20-some-plus men in his unit out of 30 plus people, had very serious physical problems manifested shortly thereafter.

And one of the things we might want to do, Mr. Chairman, is to see to it that future studies include the proximity of some of these attacks. They still haven't been really forth-coming as to whether or not chemical agents were used, but it seems to me that the man had been trained as a soldier to detect chemicals, the use of chemicals or biological weapons. He made that personal detection based on his training. The equipment that they had set up sounded alarm, suggesting there was an agent in the air, which was consistent with his physical reaction at that time. I think it is very important that we see to it that future studies include, perhaps, some tests of that as well.

And I thank you very much for your testimony.

Mr. EVANS. Mr. Chairman.

Mr. MONTGOMERY. Thank you, Mr. Evans.

Over the years I have found that departments of government sometimes have a problem cooperating with each other, and it would seem to me in a situation like this, Ms. Hewitt, that the Department of Defense and the Veterans Department has got to totally cooperate with each other to get to the bottom of this situation. We have to get the information from the Defense Department for this committee to move ahead and to see that veterans are treated fairly.

What is your assessment of how these two Departments are working so far to come up with some answers that we can use?

Ms. GELBAND. Well, I think they have both been carrying out their mandates. But, as I mentioned, when the mandates were first given, the main concern was the oil fires because that is what was so visible and looked like such a potential hazard. The mandate

hasn't changed, and yet now we are seeing that there may be a lot of other things that aren't being picked up in that mandated information system and that aren't really being addressed.

Mr. MONTGOMERY. In the Department of Defense is it——

Ms. GELBAND. Yes. Because they have been spending all of their effort to develop a system to look at the effects of oil fires, which is what they were originally tasked to do by the Congress. While there are certainly people in DOD looking at these other questions, most of their effort is going into the oil fire problem. And it may just be that there needs to be a slight redirection.

Mr. MONTGOMERY. That is a good point.

Mr. Chairman, are there any defense people here this morning, do you know?

Mr. EVANS. General Blanck will be testifying today.

Mr. MONTGOMERY. Good.

Mr. EVANS. Will the gentleman yield for a minute?

Mr. MONTGOMERY. Yes.

Mr. EVANS. Ms. Gelband, would you be recommending then that Congress broaden the mandate by legislation? We won't be able to broaden the mandate without legislation, is that correct?

Ms. GELBAND. I don't know if you can. I am not sure.

Mr. EVANS. Thank you. I yield back to the gentleman.

Mr. MONTGOMERY. Thank you. I would hate to have to mandate it. It is their responsibility. I would hope that the Defense Department would get on this as quickly as possible.

You mentioned something about an oversight committee? We have an oversight committee here. Why would we need any more oversight committees?

Ms. GELBAND. Well, as wonderful as this body is at oversight, I was thinking of the more boring kind of scientific group—epidemiologists and physicians, people who would be thinking about the technical uses of this information. What was suggested by our group of advisors was a technical body which also would include veterans representatives, so they could deal with both the technical issues and the issues that were of greatest interest to the veterans on a technical level.

Mr. MONTGOMERY. Thank you, Mr. Chairman.

Mr. EVANS. The gentleman from New York.

Mr. QUINN. Thank you, Mr. Chairman. And thank you, Ms. Gelband for your testimony.

I want to associate myself with the remarks of Mr. Kennedy a little bit earlier this morning. We have heard testimony last week and at four other hearings from veterans and others. We heard from a mother last week who lost a son 11 months after he returned from the Persian Gulf. We heard from a veteran who left the hospital to come here and testify and then returned to the hospital.

I don't know why these folks would not be telling the truth. I don't know why we can't get the attention of the VA and DOD.

You make an excellent point, and so does the chairman of the full committee, that we need to get these two government offices working together. You are very polite when you say that they need a slight redirection. I couldn't agree with you more, and appreciate your candor.

Mr. Kennedy said that the VA and the DOD needs to convince the veterans that they are helping them, and I couldn't agree more. I think that the VA and the DOD needs to convince me that they are working for the veterans. I think they need to convince this committee and the rest of the Congress that they are.

You mentioned on the first page of your testimony that the law mandating and creating the Registry also mandated that the OTA assessment in the long term set up an arrangement for review. I am interested to know, if you can tell us, what the long term means. How long?

Ms. GELBAND. Well, I think the long term at the moment is 10 years. I believe the agreement with the Institute of Medicine, which is what you are referring to——

Mr. QUINN. Yes.

Ms. GELBAND (CONTINUING). Is for 10 years.

Mr. QUINN. Okay.

Ms. GELBAND. But I also think that we all know that there is more than 10 years to go.

Mr. QUINN. And in terms of an oversight committee, I made a note of that when you mentioned it earlier today and the other members have probed that a little bit. Could I explore that with you, just for a few minutes?

I think you are suggesting that if we are going to get the VA and the DOD cooperating together, redirected a little bit differently so that they are sharing information, they are sitting down with each other, that maybe an oversight committee of these people with some veterans group be formed.

Ms. GELBAND. Yes.

Mr. QUINN. And how would that help you? What would be the best thing that could do?

Ms. GELBAND. In our view, they would be responsible for looking at the bigger picture and they wouldn't be involved in carrying out specific mandates, which VA and DOD are extremely busy doing. VA and DOD have been given difficult tasks and they are working on them. But I feel that they haven't had time to take a look at a broader view.

Plus from what we know, we are not happy that there is enough scientific oversight in epidemiology to think about what the ultimate uses of these information systems might be. I think the Institute of Medicine, when they get started and when they start reporting, will be using the kind of people necessary for this task. So maybe at that point they will fall into that oversight role. But right now in these developmental stages that are so important, we don't feel there is a group like that.

Mr. QUINN. Okay. Thank you.

And, Mr. Chairman, if your suggestion to broaden that mandate helps facilitate what we are hearing this morning, it sounded to me like you were headed in that direction, I would be willing to help you with that. I think it is a great idea.

Ms. Gelband, thank you for your answers to the questions. I appreciate it.

Mr. EVANS. Thank you. I look forward to working with you.

The gentleman from Alabama.

OPENING STATEMENT OF HON. SPENCER BACHUS

Mr. BACHUS. Thank you, Mr. Chairman. I would just like to emphasize agreement with your statement for a joint oversight committee. It is needed very much. Because I think the VA is moving ahead after a long slow start, because they are dependent upon the DOD to demonstrate to them that there was some exposure, and the VA, I think, has made a very good start on this.

And, frankly, I am not impressed with the Department of Defense's response to this problem. That is why I think the joint oversight committee is very, very important.

Thank you.

Mr. EVANS. The gentleman from Georgia.

Mr. COLLINS. Thank you, Mr. Chairman. In reference to the cooperation between DOD and VA several—well, approximately 2 months ago we contacted both and suggested and requested that a joint task force be formed to go down to Columbus, GA, and talk to those reservists down there.

We were notified by DOD that they were going and are going on December 4 and 5. Last week in the hearings we had here, it was mentioned to the DOD as well as Major General Blanck about the fact that the Department of Defense was going down but VA had not been included.

Since that day we have received confirmation from the Department of Defense that a VA person will be accompanying them to Columbus, GA. However, we have not received confirmation that the VA will be accompanying DOD to Al Jubail, Saudi Arabia, for the same purpose.

But there seems to be some small step toward some cooperation between the two agencies in trying to get to the bottom of what happened over in the Persian Gulf as well as what we can do to see that these people get the proper help. The proper help that they so deserve.

It is a small step. However, in terms of what we have been going through for the last 2½ to 3 months and what some of these veterans have been going through for the last 12 months, I consider it to really be a giant step.

I too picked up on the comment you made about the oversight committee. I think that could be very helpful, as well as these committee hearings, in trying to get to the bottom. I know when I met with the Department of Defense a couple of months ago we had a roomful of people. We had a commander from the Persian Gulf who was actually over the reserve units from Columbus, GA.

A lot of mention was made to the fact that the logs, the daily logs of events that happened would reflect whether or not there was a chemical attack on the troops in Al Jubail. However, when I asked the question, Have you actually reviewed those logs? The comment was, "No, we have not."

So maybe if we—I know when I would get to the bottom or somebody actually reviewing logs or bringing the logs and then letting this Congress know exactly what happened over there. We are trying at least to get to the bottom of what happened.

Again, thanks for allowing me to participate. And thank you for your testimony.

Mr. EVANS. My colleague from Illinois.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

Ms. Gelband, in your summary you list other concerns that have surfaced in addition to the oil fires. For example, you include inoculations and depleted uranium, vehicle paint, diesel fumes and chemical warfare agents. You say that these should be acknowledged and evaluated whether or not they represent, in your words, "real threats."

I am just wondering what you meant by real threats. What level of evidence do you need for it to be real? Are there other threats out there that you might think are fake threats to the veterans?

Ms. GELBAND. I was listing things that have arisen in the popular press and in records that may well be threats to health. We don't know if people were actually exposed to all of them. Some things might certainly be threatening to health if you are exposed. If no one was exposed, well that would be a good thing, and they wouldn't be real threats.

So, no, I don't have a level of evidence. My point there was just that the data systems that have been set up weren't designed to look at those things, and that we need to be able to look at them and to assess whether they are important and whether we really should be looking at them.

There are all kinds of things that are going to come up over the years, some of which will be more important than others, and we should have some way of sorting them out. The mandate given to DOD and VA was really only about oil fires. So, just to acknowledge that there are these other things that we should be concerned about.

Mr. GUTIERREZ. I was particularly interested in one suggestion that you had, and others alluded to it here this morning, in terms of the task force. To ensure the credibility of the Pentagon's report, you say that a representative group of veterans should offer input before the report is released. I support that idea very much because I believe that nobody knows this issue better than the men and women who lived through it.

Can you talk to me about what assurance you think there could be that veterans would indeed have an opportunity for real input in a final report?

Ms. GELBAND. I am not sure what you are referring to. Where are you reading from?

Mr. GUTIERREZ. It says—on page 9. It says "It is important to ensure credibility that a mechanism be developed to allow input and review from representative groups of veterans before the report is issued. In addition the report should be written so that it is readily understandable by individuals not schooled in military operations."

Ms. GELBAND. Right. These are two reports that we recommended that DOD and VA put together about what actually happened in the Gulf. And this one in particular may be a unit-by-unit description of what people's major activities were, that should be put together based on military records. Veterans who served in those units should be able to review that information and make sure that it is accurate, because we all know that sometimes what gets written down isn't exactly what happened, and we just want to make sure that we have a history of the war which will be helpful in doing health studies later on. That it not only be accu-

rate according to what was recorded but what people remember actually going on.

Mr. GUTIERREZ. Well, let me just suggest that I highlighted that part because I think it is very important to much of what we have been trying to do and much of the obstacles that have presented themselves as we look at the Gulf War and the effects to the veterans, and whether or not they are being taken seriously, and whether any report is going to be taken seriously, whether their indication and their testimony, their beliefs about what happened to them are being taken seriously by anyone.

So when I saw that in the report, it seemed to me that we need to have real assurances that they are going to have a real impact on the final report, and that we need to make a real commitment to full and fair consideration to those comments that the veterans—because, see, I really don't believe we would be here today having this hearing if there had been given fair consideration to what veterans have to say.

And I think that it is going to be a major obstacle, because in everything that we have heard from the very beginning, they basically have been telling veterans, "Well, we are not quite sure which one of you are lazy or malingerers and want a government pension to live off of. It is fine to send you off to the Gulf War. We are not quite sure."

They have questioned. They have questioned. The Veterans Department and many have questioned the integrity and credibility of the veterans that have served in the Gulf War. They didn't question that integrity or that courage sending them there or when they came back. We all agreed and applauded and there were many parades for them. But now when they are a little sick, they wonder.

And so the tests have not been about chemical warfare or the reactions or the agents that have been there, but whether or not the veterans are telling the truth. They said, "Well, you know, you might have a psychological problem." And so they have been given medication for psychological problems.

And I really think that the real psychological problem that we have had up to now-- there is one. It is called denial on behalf of the Department of Defense and the Veterans' Affairs Department. And in order to break through that it is going to be very essential that you and others, as you compile your information, give credence to what veterans are saying in a real meaningful way, and that before they come—before those veterans are asked to come before that they understand that they are going to be believed and that they are not going to be questioned, and that their integrity and credibility is not going to be at stake as it has been thus far.

Thank you very much for your testimony here this morning.

Mr. EVANS. The gentleman from Massachusetts.

Mr. KENNEDY. Thank you, Mr. Chairman. Thank you all for coming and testifying this morning.

I think that you can play a very important role in trying to define much more clearly the exact role that now needs to be played by both VA and DOD. I appreciate your notion that somehow a joint task force ought to be assembled, but I think that given the lack of enthusiasm that we have seen by both agencies to get to

the bottom of this issue requires us to be somewhat more definitive in terms of what we expect.

Now, I have read your basic conclusions here. One, VA should focus immediately on revising the examination protocol. Two, terminology used by the VA and DOD should be brought into conformity where appropriate. Three, a joint oversight body for the VA and DOD Registries and their related activities should be appointed, and would enhance existing coordination and cooperation for information on exposures and other experiences of Desert Shield-Desert Storm should be assembled by DOD into a qualitative history of the Persian Gulf theater of operations. And, five, DOD and VA should assemble annotated inventories of all sources of relevant health and demographic data other than Registries for Persian Gulf veterans.

It sounds good. But what it doesn't do is recognize that right now you can have the Registry, but if you got a guy down in Houston who is saying, "These are nothing but a bunch of malingerers," who is running the Houston VA, it doesn't work. I mean, so the fact that you coordinate a joint response between VA and DOD isn't really going to get to the root cause of the problem.

We heard testimony at a hearing over a year ago by a professor at M.I.T. This professor's name I can't—I can't quite remember what his name was, but he—Thall, I think was the guy's name. But anyway, he said that his life's work at that university was to take the kind of chemical exposures that many people have in industry today—oil workers, people that work in fires, and a whole range of other industrial personnel—and determine the level of exposures that they face on a day-to-day basis and the kind of sicknesses that can be predicted would occur as a result of those exposures.

Now, it seems to me that it ought to be possible for an organization such as OTA to define very clearly in very specific steps what is necessary to draw certain conclusions about cause and effect. What we have got is a basic problem where on the one hand, as Mr. Gutierrez just indicated, there is a sense that this is a bunch of malingerers or people that have head cases or are complaining about something other than an issue that was directly related to an exposure of chemical or biological or other kinds of environmental exposures that they encountered in the Persian Gulf versus the notion that these fellows are really sick.

What I would like to ask is whether or not either of the three of you—any of the three of you, have the capability of defining in a very systematic, specific manner exactly what would be required for us to be able to get a handle on whether or not the depleted uranium, oil fires, perhaps a nerve gas or a biological agent that went off and was hit by a SCUD being hit by a Patriot thousands of feet above the air, and the best guess at what kinds of illnesses might be caused by an exposure to those chemicals that would have been vastly dispersed versus if the bomb goes off right next to you.

How do we begin to get a handle on whether or not the VA and DOD are really going to the depth that they need to in order to make these determinations?

And I will just finish by suggesting that even on the most fundamental issues of just following up on specific cases that have

come in, that we have gotten on this committee, we still can't get the DOD to follow up. So my sense of the lack of the ability of us to go in and get the job done, just in terms of following up on specific cases is indicative of the lack of enthusiasm that they have for actually getting to the root cause of this problem.

So, what I would like is OTA to tell us what steps should be gone through in order for us to feel confident that we are going to get at the root cause of this problem. And I guess my sense is these five steps aren't even close to going to be to get there.

Ms. Gelband.

Ms. GELBAND. Well, a couple of things. First, the Institute of Medicine's role over the next 10 years is to do at least some of what you suggested: to look at exposures that have been suggested might be harmful and to also review the results of the VA examinations. I understand that there are about 10,000 Persian Gulf veterans who have been examined and their records are now available to be looked at systematically. That was the purpose of the committee's mandating that the Medical Follow-up Agency review all of that information on an ongoing basis, and to do that they have a contract jointly with VA and DOD. It wasn't OTA's role to do that.

Mr. KENNEDY. No. But I actually did, I think, sponsor that amendment, and that was, again, our committee's response to the lack of diligence on behalf of DOD and VA to get to the root cause of it. So what I am saying is that, you know, what you have got is sort of this ad hoc group of Congressmen, you got Glen Browder and Matt Collins who come from the DOD committee who are interested in this issue. You have got a bunch of folks up here that are kind of scattershot trying to get at—get a handle on this issue, Ms. Gelband, and it seems to me to be a very reasonable request to suggest that we don't feel, first of all, that it is right to wait 10 years. My God! We ought to be able to do better than that.

What we are trying to do is say aren't there a series of questions that could be asked—I don't mean to make you laugh. I am just trying to say there has got to be a series of 5 or 10 or 15 or 25 or 35 steps that we can ask DOD and VA to take up that are perhaps going to be a little more detailed than we are going to do on the seat of our pants up here that ought to define how they should approach this problem. And that is something that I would think that OTA would be in a very good position to help us define so that we can ask those agencies to comply.

Ms. GELBAND. Well, first, the Institute of Medicine has a 10-year commitment, and they should be reporting regularly during that period. That is how it was envisioned. That they would be reviewing this information regularly and feeding back regularly. I don't know what their plan is at the moment, but they were to carry out that ongoing oversight of the data.

In terms of the bigger picture of all of the things that need to be done to investigate and get to the bottom of things, as you say, our mandate was specifically to evaluate the activities that were mandated by the Congress——

Mr. KENNEDY. But isn't it your job to provide information to the National Academy of Sciences to make considerations for further epidemiological studies and the like? Isn't that part of your mandate?

Mr. BEHNEY. Well, what we can do is, in response to your question, we could report back to the committee with a long memo to you which would lay out how to respond to your question. It would include examing the literature to see what's known about cause and effect for certain exposures, how the National Academy of Sciences and Institute of Medicine are responding to their responsibilities, and how that fits into what you are asking for.

It would be difficult for us to respond today on the strength of evidence between exposures and the specific diseases we are looking at.

Mr. KENNEDY. I wasn't really asking that. I wasn't expecting you to provide me with that plan this morning. What I wanted to do was determine—my understanding of what OTA does is provide these kinds of specific recommendations when there is kind of a dilemma or a problem or a lack of enthusiasm by an agency to fulfill the job that the Congress is asking.

So, we need some help in defining the series of questions that will allow us to get to whether or not there was a cause and effect relationship between the work that was done by our troops in the Persian Gulf and the illnesses that they are currently feeling. And what I want to do is just make a very simple determination whether or not your agency is the proper agency to help define for us what those series of questions might be.

Mr. BEHNEY. It is subject to our congressional board of directors as to whether we actually undertake it, but it is an appropriate role for OTA. It is the type of thing we do for Congress.

We don't initiate anything on our own, as you know. So if the committee asks us to help them with that process, think it through, see what would be needed and make suggestions about how to get where you want to go, that is an appropriate role for OTA and something that we do for Congress.

Mr. EVANS. Will the gentleman yield?

Mr. KENNEDY. Certainly.

Mr. EVANS. We hereby request that information.

Mr. BEHNEY. If you could put it in writing it would fulfill our statute actually.

Mr. EVANS. Thank you.

Mr. BEHNEY. But we would be happy to get a letter like that.

Mr. KENNEDY. I would be happy to put it in writing, but given how difficult it was to get you to get this far, I am not sure we are going to get to the root cause of the problem. But anyway, I would be happy to and we look forward to any help or consideration you might be able to give us in trying to define what these issues are, all three of you.

It really does, I think, warrant some scientific and medical analysis that I don't believe was ever anticipated that Members of Congress in and of themselves ought to bring to the table. This is what OTA is supposed to do. So I think that it is entirely appropriate for you to come forward and give us the list of questions.

I want to know what happened out there. That is what these troops want to know. They are not looking for money. They are not looking for some way to hurt the government. They are looking to be told that the service that they provided is causing them these illnesses, and it seems to me to be very reasonable to expect that

OTA could help define for us the series of steps that we should expect both DOD and VA to go through in order to make those determinations.

Maybe you are never going to get to it and be able to definitively say this occurred because that took place. But we might be able to make a very well-educated guess. My sense is that that is what you are probably going to be able to do.

But, if we don't ask the right questions and we don't do it in the proper way, then somebody is always going to say the study was flawed. So I want to make sure that we go through asking the questions in the proper manner in order to make the proper conclusions.

Sorry, Mr. Chairman. Thank you very much.

Mr. EVANS. The time of the gentleman has expired.

The gentlewoman from Indiana.

Ms. LONG. Thank you, Mr. Chairman. I don't have any questions for this panel, but as a result of the panel's testimony I do have some questions for panel five. And I am going to have to leave to go to another meeting and I am just wondering if I can submit my questions for the record.

Mr. EVANS. Those will be submitted for the record, and the answers thereto will also be submitted for the record, and we appreciate your attendance today.

(See p. 237.)

Mr. EVANS. We are very pleased to be joined by another gentleman from Alabama, a very active member of our subcommittee who joined us in his hometown last Friday at the Birmingham VA facility, Spencer Bachus.

Mr. BACHUS. Thank you, Lane.

Ms. Gelband, we have been doing some reading on Iraq and their use of biological warfare during the Iran-Iraq War, and I think there are several documented instances of Iraq and Saddam Hussein using biological warfare.

I noticed in your assessment you didn't list the possibility of biological warfare, and I notice the so-called binary theory where you mix chemical warfare agents and biological warfare agents, and I think that it has been documented that Iraq on occasions used that, and that Russia used it in Afghanistan, and it may have been used in Laos. Was that considered?

Ms. GELBAND. I don't think that was part of our task, really, to consider what other things may have been happening. I would hope that the Institute of Medicine would consider that kind of information and perhaps review any medical information from those other instances. We were asked to review what had been done in response to the mandates of the VA and DOD and it just didn't fall within our purview.

Mr. BACHUS. So, the use of biological agents really wasn't considered?

Ms. GELBAND. We didn't consider any agents specifically because we were concerned about the ability to investigate that sort of combination of things and any other agents or exposures that arise. It would't be done by us.

Mr. BACHUS. Can our detectors detect biological agents, especially, say, mycotoxins?

Ms. GELBAND. You are way out of my field. I don't know.

Mr. BACHUS. I know you mentioned the fact that the nerve gas and the Sarin and the mustard gas were very low concentrations. But I wondered if our detectors can detect these mycotoxins.

Mr. BEHNEY. I hate to keep saying we didn't look into that, but our response was to the congressional mandate to DOD and VA, which is primarily concentrated on oil well fires, and the reason that we listed some other possible agents, exposures of various kinds, is because the current efforts are not going to be able to allow us to look at things as you are suggesting.

So, we are agreeing with you that a capability needs to be developed in order to find out if those exposures took place. But we didn't look at that and so can't answer your specific question. But we agree that someone has to be able to.

Mr. BACHUS. I think with Sarin and with this HD, the mustard gas, there is a lot of research on the exposure levels and what the results are, but I think when we get into whether biological agents were used, we really lack the expertise, at least I have seen nothing in these studies to indicate that we have. Is there a possibility that biological warfare was practiced by Saddam Hussein during the Persian Gulf War?

Mr. BEHNEY. I just don't know how to answer that. Nothing we have done would give us any base from which to answer that.

Mr. BACHUS. Either way?

Mr. BEHNEY. Yes.

Mr. BACHUS. To either exclude it or otherwise? What I am concerned about is that we have spouses and children of our Gulf War veterans who are exhibiting symptoms of some disease or infection and I don't know how we account for that. Have you got any thoughts on that, as to why?

You all have seen evidence of that too, I am sure, or complaints by veterans that their children and their spouse are coming down with symptoms.

Mr. BEHNEY. I don't know anything about that. We are not interacting directly with veterans or their spouses.

Mr. BACHUS. Have you received information from the VA that that is being reported?

Ms. GELBAND. No we haven't. In the VA examination they do ask about reproductive effects in spouses—about births—but not about other illnesses.

Mr. BACHUS. Yes. Are you aware of that? Were you aware that, as we are hearing from veterans back in our district, that their wives and their children are exhibiting some of the same symptoms that they have?

Ms. GELBAND. We don't have that information.

Mr. BACHUS. I don't know how widespread this is.

Ms. GELBAND. I haven't seen anything.

Mr. BACHUS. No further questions.

Mr. EVANS. We want to thank this panel for testifying. We appreciate your work.

Because of the technical problems we have been having, we are going to recess for 5 minutes so they can be corrected.

[Recess.]

Mr. EVANS. We will now reconvene. If everyone could be seated, please.

The members of our second witness panel are Troy Albuck, Tim Striley, Paul Egan, Kimo Hollingsworth, Dennis Cullinan, and Brian Martin.

Troy is a Persian Gulf War veteran from Barrington, IL. Tim is a Persian Gulf veteran from Fulton, IL. Paul is Executive Director of Vietnam Veterans of America. Kimo is a Persian Gulf War veteran who testified before the subcommittee in June. Today he is testifying on behalf of The American Legion. He is Assistant Director for the Legion's National Legislative Commission. Dennis is Deputy Director, National Legislative Service, Veterans of Foreign Wars of the U.S. He is accompanied by Brian Martin, a Persian Gulf War veteran from Niles, MI.

Without objection, your entire statements will be entered into the record. Troy, once you are situated we will start with you. Troy is from the Chicago area. We welcome him today as we did on November 6 last year when the subcommittee was in Congressman Gutierrez's district.

If you could help us, Tim. Please pull the microphone over to Mr. Albuck. Troy you may proceed.

STATEMENTS OF TROY ALBUCK, ACCOMPANIED BY KELLI ALBUCK, BARRINGTON, IL; TIMOTHY JAMES STRILEY, FULTON, IL; PAUL S. EGAN, EXECUTIVE DIRECTOR, VIETNAM VETERANS OF AMERICA; KIMO S. HOLLINGSWORTH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION; DENNIS CULLINAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE U.S., ACCOMPANIED BY BRIAN MARTIN, NILES, MI

STATEMENT OF TROY ALBUCK

Mr. TROY ALBUCK. Thank you. The first thing I would like to do is, I wrote something but I am going to depart from that for just a second.

We are spending a lot of time talking about what kind of agent, biological, chemical, where it came from, who used it, did it really happen, did we detect it—that would be much the same as if I walked in with a sucking chest wound from a gunshot wound and you trying to figure out what kind of rifle shot the bullet before you give me any medical attention. Okay?

This is a wound that we sustained in combat that just had a little lag time on it. Okay?

Unlike, you know, the lucky guys who just get gunshot wounds and get it treated, we are the unlucky ones that got something that took some time to show up. Okay.

Honorable ladies and gentlemen of the House of Representatives, I want to thank you for this opportunity to speak.

Growing up I knew I could do anything I wanted, but the key was to find something worth doing. I thought I had found it, a most noble endeavor, defend the Constitution.

I enlisted in the Army in 1984 when I was 17. I made sergeant at 18, and was commissioned a lieutenant at 19. I was an airborne

ranger, infantry officer from the 82nd Airborne Division with a combat infantryman's badge from Panama and Iraq by the age of 24. I had expected to be a captain within months and a colonel by 35. The country's money problems changed that course.

I would have stayed with absolutely no pay, but no one seemed to listen to that. I had 30 days to take my new family back to where I came from. Unknown to me, I also carried a chemical wound sustained in Iraq. Gradually that wound began to take its toll. And I will pause here to say this.

I volunteered, so I just have to take what I get. However, my wound has caused identical wounds in my wife Kelli and my son Alex. They did not volunteer. They did not take my oath. They have been drafted against their will to fight the enemy. They fight untrained. They fight unarmed. And they will never receive the purple heart they have earned and deserve.

Now, before I get carried away with all this complaining, let me outline the problem and your solution.

So, we fought a war, and a lot more people got wounded than we initially thought. The majority of the wounded, though, feel they must conceal their wounds or they will be eliminated from the service. That is a monumental problem. Additionally, many of the Gulf War vets have already been separated from the service and the only recourse for these families is to seek medical attention from the VA Medical Centers.

In 1865, Abraham Lincoln charged the VA "to bind up the Nation's wounds, to care for him who shall have borne the battle and for his widow and his orphan." Unfortunately, the VA fails to accomplish this clearly defined mission. The VA is choked into inaction by regulation and restriction.

So, what can we do for our wounded who are afraid to seek care, who have VA care for themselves and not their family. The answer must provide for entire families and should also make it easier for those who must create a medical solution.

One of the major obstacles to the medical solution is the length of time it will take to study. I think the number we are talking about is 10 years. We will probably just be the most researched bunch of corpses by then.

The true numbers of wounded and dying are unknown. So the solution must draw the wounded out of concealment and provide for those too wounded to provide for families while research continues. My families' experience should provide you with a good example.

My wife Kelli is 23. My daughter Shelby is 3½, and Alexander is almost 10 months old. After the Gulf War we had two miscarriages during 1992, one in January and the other in May. This nearly tore us apart, and for this we sought counseling.

In October, Alex nearly miscarried, but the doctors managed to halt the delivery. My wife and I had both developed red spots and began to collect a series of other symptoms. My symptoms also included itchy, painful, bull's-eye red spots that began to spread. I began to swell. My lips split open and bled. My eyes swelled shut and my throat swelled closed.

An ER visit and steroids reduced the swelling, but the spots lingered and the fatigue continued to increase over the year. It only

took my family doctor a week to give up and tell me to go to the VA where they "know about these things."

I spent more than a year trying to coax answers out of the North Chicago VA Medical Center. Even more symptoms have developed: breathing problems, digestive problems, diarrhea, bleeding gums, hair loss, difficulty sleeping, and hearing problems.

Alexander had a March 7 due date, but he arrived on January 20th, 7 weeks early. His fight was tough from the start. In addition to our red spots, he had spinal meningitis, strep reinfection, cranial hemorrhage, and an immediate need for respiratory ventilators to survive.

Initially, the neonatologist said he had less than a 20 percent chance to live. During his first 3 months he encountered many reverses and on three separate occasions we were called to spend our last hours with him. They cut out the top half of his left lung and inserted a dozen chest tubes, one or two every time a lung would collapse. He was fed by a tube through his nose and was on and off ventilators five times.

He generated 1,200 pages of medical records. He had a half a million dollars lifetime medical insurance. It was entirely gone in less than 90 days.

Alex's prognosis includes vision and hearing problems, growth retardation, baby emphysema, and cerebral palsy. He requires physical therapy, oxygen, suctioning, breathing problems and two monitors. He has been approved for SSI disability but I had to personally beg his doctors to continue to treat him after the regular insurance was gone. I know that he never would have survived in a military or VA medical facility.

Alexander stabilized, due in large part to my hero wife who has trained herself to be his doctor, nurse, respiratory therapist, physical therapist, et cetera, et cetera, when we began to care for him in our home. But Kelli and I started to get worse and worse, so we made the decision that I would go to the VA alone and I would not leave until we had an answer.

I came from Houston. I am still a patient there. I am not sure I am going back.

I cannot get medical care for my wife and son, but I tried to get the VA to give me the key to a medical resolution of our chemical wounds. I also wanted to help all the Gulf War vets that have been calling me to say that their family is wounded but they are waiting on me to get the solution in place. Currently, I am in the Houston VA, but it has taken a week to get the real truth: At this time there is absolutely nothing that can be done for any of us other than to comfort us because there has not been enough research.

In order to make the wounded available and care for all members of the wounded families, I recommend that all those suffering Persian Gulf syndrome be put on active duty and made comfortable and available for research. It will also ensure that their jobs are protected by your law.

We are only asking for medical attention for the wounded. We are only asking that we are available for research. We are only asking for the same level of care that the United States is giving Iraqi ex-POWs and their families, 200 of which are given asylum in the county next to mine. This would get us off public aid and

prevent many VA home loans from going into default. Because, ultimately, if we cannot see our way clear to help our wounded veteran families, many reduced to public aid, how can we offer this level of health care to the entire United States under health care reform.

Airborne rangers lead the way.

[The prepared statement of Troy and Kelli Albuck appears at p. 168.]

Mr. EVANS. Thank you, Mr. Albuck. We appreciate your testimony.

Tim, please pull the microphone directly before you.

STATEMENT OF TIMOTHY JAMES STRILEY

Mr. STRILEY. Good morning, Mr. Chairman, other members of the committee. I appreciate the chance to speak.

My name is Tim Striley and I am a veteran of Operation Desert Shield, not of Operation Desert Storm. I deployed to Saudi Arabia on the 14th day of September of 1990 with the 101st Airborne Division, Air Assault, of Fort Campbell, KY.

Upon my arrival, my fellow soldiers and I were detailed to set up tents, a tough job on the hard earth of King Fahad International Airport. After 2 days of doing this I suffered a second degree sunburn on my face, neck and arms. This healed up over the course of the following days and everything seemed to be all right.

Weeks passed before, during the guard duty one day, my neck began to burn. When I reached around to the back of my neck, my hand returned with pus and blood all over it.

After finishing my guard shift, I immediately went to our prescribed medical unit seeking relief. The doctor there prescribed topical creams to combat the unknown rash. Over the course of the next days, the rash had spread to my face and to my scalp. The clinic doctors at this time prescribed a different regime of topical creams. Again, there was no relief.

I returned later with the same lesions that were described as weeping and crusted, at this time also experiencing gastrointestinal discomforts including fever, vomiting and diarrhea. This time there were new medications for the intestinal problems and more creams for the rash. By this time the sores were also on my arms and hands.

The internal problems seemed to go away and I was then sent to other medical units for evaluation. This continued until I was given a shaving profile. I was told to grow a quarter inch of beard hair. Again, with no relief. They put me on oral steroids, one of which was Prednisone.

On November 21st of 1990 a strange incident happened at King Fahad airfield. At this time I was already sick. I had some sort of lesions, probably a secondary infection. We got hit with something that day. Our ammunition depot blew up. We had a missile that hit. We were told it was a Hellfire missile fired from an Apache helicopter. Whether that was true or not I have no idea. I am not at liberty to say.

The sores after this time worsened. I started having more problems. And on that particular day I was already unable to wear a mask. I could not seal a mask at that time.

My battalion commander, Lieutenant Colonel Carden, stepped in to help and had me evaluated by the Division Surgeon General, Colonel Kimes. I was evacuated to the Navy's 5th Fleet Hospital in Al Jubail. It was there that I first showed signs of some improvement during Desert Shield. I stayed there under sterile conditions and was on a strong course of medications, and it did somewhat clear up. Shortly after returning to my base, I again got sick.

During this time, December and January of 1990, my unit's gas alarms went off frequently. Each time we immediately donned our protective mask and occasionally our entire protective suit.

One particular occasion, we were ordered to seek cover in underground tunnels. During each of these occurrences we were told that SCUD launchs had been detected. Each time we were told "all clear" and the missiles were said to have either been exploded prior to, prior to now, coming over the Saudi border.

On one of these particular occasions a civilian airliner even landed with a bunch of troops that ran out of there in their MOPP gear, fully decked out, ready to go. The crew of the civilian aircraft came off of the plane running for cover, running into the bunkers. It got pretty serious.

At this time it was evident that my protective mask would not seal. Senator Tom Harkin of Iowa stepped in and inquired about my health. Senator Harkin was told that I could still seal a protective mask, which contradicted all the training we had been given pertaining to sealing a mask. With his continuing inquiry, my commander told him that we were not expecting to be gassed. According to my commander, even if I could not seal a gas mask it was irrelevant.

He (Senator Harkin) finally had to step in and have this commander send me back to the United States because of these sores. I could not even eat in the chow hall because of these unsightly sores. These sores were so bad that they were bleeding and oozing. That, and the fact that I could not seal a mask, is why I was sent back to the United States.

But right before I left, my company commander said, "Well, Tim, we are going to send your medical records back via the U.S. mail."

"All right, sir. That is fine. Get me out of here."

It was the day before "K-Day". Fine with me. That was the last time I seen those medical records. And that seems to be occurring quite a bit throughout this—what we are finding here. Many of our records are now "Missing."

When I asked him, after they came back from the Gulf War, what had happened, he said those were destroyed in the war.

My dermatologist at Fort Campbell, KY, did some tests on me, allergy tests and what not, and said that I had contact dermatitis. She also said I had eczema and it was a family hereditary condition. That my siblings had it. That was a lie. I don't know where she got that from. She tried to have me discharged for false enlistment. I don't know where she got that information from, nobody in my family has eczema or dermatitis .

Over the course of events, in May of 1991 my fiancee, now my wife, suffered a miscarriage at 4½ months into her pregnancy. They have found—after the miscarriage, she started hemorrhaging and they took her in the emergency room. They made her have a

livebirth and let the baby die on the table. All right? The medications that could have helped her was not cost effective. That was the general idea of what was going on there.

They let the baby die. After the delivery they gave Karen a DNC where they found a strange infection in her uterus. They could not figure out what it was. They said it was like a venereal disease, but tested negative for everything. They did a PAP smear later (after antibiotics) and said everything was fine.

Well, after this time my unit started having problems with me. They started calling me a malingerer, a hypochondriac. I was given an Article 15 for strange reasons. It was just a really bad time at that point.

I was honorably discharged on August 30th of 1991. At this time I immediately filed a VA claim for service-connected disability in which my records pretty much stood alone. I was rated at 10 percent for eczema.

In September of 1991, my wife again had a miscarriage. It happened the same exact way. She was still on active duty. The same exact way. And once again the doctors came back and said, "We found an infection. We don't know what it is. We can't figure out what to do about it." She went through a long course of antibiotics again. In November she saw her GYN doctor again, a pap smear was done, and she was "okayed" to get pregnant again.

On January 16 I came here to Washington, DC, and was in a press conference to discuss this issue. This is how early this has been going on in my instance. During this visit I visited Walter Reed Army Hospital and was tested for the parasite leishmaniasis. This test came up positive. The actual quote was, I tested positive on the low end of the positive side, and I was referred to my VA hospital.

At the VA hospital I had a bone marrow test done that came up negative.

Months passed and I started seeing civilian doctors. At this time I had given up on the VA. They had lost my medical records, a big mess had occurred. On August 25 my wife actually delivered a baby. Six weeks after this birth she hemorrhaged and ended up in the emergency room. This time with civilian doctors. She was out of the Army. They found a strange infection and the doctor, and I quote, "found a strange infection that acted like a venereal disease but tested negative for everything they could test." .

This has been ongoing. Now, my doctor has found a cyst covering over 50 percent of my right kidney. They have done biopsies on this cyst. They don't know what is causing it. They say they are going to take out my kidney sometime after January 1994.

My doctors are up in the air. They are holding off as long as they can hoping that this evidence, the illness we have, will come out before they have to start taking internal organs and start taking me apart piece by piece.

I have got bursitis now in my knees. Now, I have got to suddenly walk with a cane when my knee swells up. My employers are acting like—well, they are worried about it. Am I contagious? And I don't blame them.

This continues and just goes on and on and on. It seems like we are not getting any help here. It seems like nobody cares. Now,

some VA doctors are talking about post-traumatic stress disorder. Yes, some of us do have that I am sure. But some of the mental problems that are coming out of this are caused by what they are putting us through.

You have to understand people like us, here. We fought for our country, and we came back. Now all of sudden we are losing our health, our jobs, and our families. We have very little left. That is where we stand right now.

And before I close here I just want to mention also, when we first came back from the war they worried about leishmaniasis. They said that because of leishmaniasis we should stop giving blood. They put a ban on our blood. Fourteen months later they lift the ban.

Now, during these 14 months more soldiers come forward. We have got thousands of them now. The evidence is overwhelming. We have wives that are having miscarriages. We have wives and children that are starting to have symptoms. Well, why is it that we can now give blood?

Mr. Congressmen, I don't understand. But, if my neighbor's child is in a car accident and goes out and has an operation, I would lose sleep at night thinking that some Gulf War vet that might not realize that he is sick is potentially killing that child (by giving blood).

This is serious. This could be an epidemic. We can't wait 10 years. We can't wait 20 years. We have got to do this now, and that's what we are here for.

Thank you.

[The prepared statement of Mr. Striley appears at p. 171.]

Mr. EVANS. Tim, thank you very much. We appreciate your testimony.

Dennis, you are our next witness.

I have been advised that Mr. Martin is being requested on the Senate side for similar hearings. If he has a statement to make, we would let him make that statement at this time and then excuse him from any questions.

Mr. CULLINAN. That is fine, Mr. Chairman. I am just accompanying him. I am here to present Mr. Martin.

Mr. EVANS. Then we would be glad to hear from you.

Mr. Martin, do you have a statement?

STATEMENT OF BRIAN MARTIN

Mr. MARTIN. Yes, I do, Mr. Chairman.

Thank you for having me here today to testify. As you know, my name is Brian Martin. I served with the 37th Engineer Battalion, which was an airborne unit stationed on Fort Bragg also, during Operation Desert Storm and Desert Shield.

I deployed to Saudi Arabia in October of 1990 until March of 1991. On January 1, 1991, I was chosen out of 13 other people to be my battalion commander's driver. By the end of February, I was awarded an Army Achievement Medal and an Army Commendation Medal for having logged over 18,295 accident and incident-free miles.

In all those miles, I had traveled from Dhahran to Rhaffa, Saudi Arabia, along the Tapline Road many different times. On one of those trips through Hafar al Batin, in January, I had seen a SCUD

being blown up by what looked like to be a Patriot. The reason I say what looked like to be a Patriot is all I actually saw was a tail of something and a large explosion.

The next day, while driving back through Hafar al Batin, Saudi Arabia, I made a mental note of how many dead animals I had actually seen that was not there prior to that day. I even had taken some pictures of some camels that were on the side of the road that were laying dead.

My battalion had set up a forward operating base near Rhaffa, Saudi Arabia, just before the air war began. This base camp had been equipped with the M8 chemical alarms in four different areas of our perimeter berms. Thirty minutes before the air war began, I was called to the colonel's tent and instructed to start taking antinerve agent treatment pills.

Approximately 40 hours after the air war began, our alarms had started going off one to three times daily on a regular basis for the whole duration of the air war. All the way up, actually, until the day, the minute we were getting ready to join the convoy in Iraq for the ground war.

The colonel and I had drove up to the MSR Eagle near the escarpment of the border of Iraq to check on the convoy progress, and when we came back to the battalion holding area everyone was already in MOPP Level 4. We immediately went to MOPP Level 4 to find out what was going on, and we stayed in it until the order was given "all clear," which every other time these alarms would go off, we would do that. We would go to MOPP Level 4 until the "all clear" was given, which is around 45 minutes to 2 hours.

We were briefed at first that vapors from the sand was the reason for the alarms going off, but we argued that the sand was the same sand during Operation Desert Shield and the alarms never went off then as they were during the air war in Desert Storm. We were then briefed that the alarms were going off because minute traces of chemicals were detected and it was to be believed that it was from the chemical and biological manufacturing plants being blown up north of us from the air campaign. But it would not be enough to damage us, they told us.

As a matter of fact, I had even made a video letter to my wife on January 29, 1991, just after a so-called false alarm, telling her of the briefing that the colonel had given me and the rest of the battalion, and commenting on how it was only 12 days into the air war and all this stuff was going on.

I had also told the colonel that after the pills I had been taking I was feeling very strange. My eyes were affected in a moving back and forth, jiggling-type manner, my scalp felt like it was being stretched over my skull very tightly. My heartbeat became rapid and I felt like I had the jitters, like if you are on a high-speed caffeine buzz from drinking too much coffee.

My best friend, who was 24 years old, and he was my former squad leader, died of a heart attack on March 8th, 1991, during the ceasefire, in Saudi Arabia. He had moved back when we were still north. And I have always felt it was due to these pills because of the effect they had on me.

In addition to any other chemicals we are exposed to in an engineer unit, we are always building roads or ammo supply points and

in doing that we were always putting diesel fuel in different areas to keep the dust level down. We also burned diesel fuel in our kerosene heaters due to having no supplies of kerosene. We used it in our immersion heaters for our showers and our shaving water also. And, of course, all of our engineer equipment burned diesel fuel.

To this day, for the last 15 months I have experienced swollen and burning feet, swollen knuckles and loss of strength in my right hand, problems with my heartbeat, shortness of breath, fatigue, I am tired all the time but yet I have insomnia. I can hardly sleep at all. I have profusive nightsweats, to where my wife has had to change the bedding on our bed daily. I have gone to the emergency room several times for severe headaches. I have had watery, burning eyes on more than one occasion, lumps inside of my mouth. I have a bad rash on my waist, buttocks and legs, loss of hair on my legs, on the inner part of my thighs. I have digestive problems, violent choking until I vomit. I have lumps that appear on my chest like molds. I have a swollen pelvic area, thick phlegm, and my mood swings have been compared to Dr. Jekyll and Mr. Hyde.

All of these problems have rendered me unable to work and I am having a very hard time right now making ends meet with a 1-year-old son and a 3-year-old daughter and a wife who now is also infected. She is in the middle of her third severe cervix infection. She has a rash exactly like mine, and she has now become—she has gotten swelling and lumps on her left hand.

My 1-year-old son almost died at birth. They induced labor on my wife 10 days early, and his umbilical cord was just abnormally too long. It was tied in a true knot around his throat three times, his body twice, and his leg once. He now has a respiratory problem. I mean he is not—we are fortunate compared to this child right here.

And I myself am not getting better. My mental capacity is deteriorating at a rapid speed to where if I do not write something down I will forget it immediately. I have taken Indocin, a steroid called Prednisone. I must take 800 milligrams of Motrin three times a day, and I also take a steroid nasal spray for the headaches that I have. These all lighten the pain but they do not take it away.

If it was not for my family living in my parents' second home, we would be out in the street and homeless. We have absolutely no income, because my wife takes care of three children: a 1-year-old, a 3-year-old, and a 31-year-old.

Once again, Mr. Chairman, I would like to thank you for allowing me this time to tell my story on behalf of myself and the other ill veterans that could not be here today. And I would like to thank the VFW for sponsoring my way to Washington to testify, to be heard for this.

Mr. EVANS. Thank you, Mr. Martin.

Before you go I do have a series of questions I would like to ask all four veterans of the Persian Gulf War.

I think all of you have reported that alarms were set off during some attacks, is that correct?

Mr. MARTIN. Yes, sir.

Mr. EVANS. DOD has reported that an effort was made to confirm all M8A1 chemical agent alarms. Based on your personal

knowledge, was an effort made to confirm each and every M8A1 chemical agent alarm?

Mr. TROY ALBUCK. After an M8 chemical alarm sounded, you immediately go to MOPP 4 and attempt to use another piece of equipment called an M256 chemical—what it does is detects, it tells you what kind of agent you are facing.

Now, with both the M8 chemical alarm and this piece of equipment you need a certain parts per million in the air for it to react. And the kit that you use after the M8 alarm, it is sort of like a pregnancy test. You know, you have got kind of a peach color, light blue color, whatever the case may be, depending on the agent. If there is not enough agent in the air, it is going to show that there is nothing there and we are going to go out of MOPP 4. Because being in MOPP 4 is less than a comfortable experience.

So my feelings are that every time this happened we were just—the M8 alarm had just gotten enough to get over the parts per million necessary to sound but it wasn't a high enough dosage in order for it to show up on the M256 kit.

Mr. EVANS. Same experience, Tim?

Mr. STRILEY. Mr. Congressman, once again, my experiences with that were November-December of 1990. I don't recall any M256. I wasn't involved with that personally. I was an electronics technician.

However, we were told, once again, that the SCUDs never came across the border. They had been exploded in the air.

Sounds pretty curious to me. But then again when you are talking about the possibility of a biological agent, and there is no way to test for that. It would be just like Hussein. I mean, he has used these weapons against his own people, why wouldn't he use it against us?

Mr. MARTIN. Mr. Chairman, these alarms would go off, like I said, one to three times a day for 40 days. It was about 3 to 4 days into the air war when they started going off. We would almost set our watches by them. We would make jokes. You know. Well, we haven't had a chemical alarm yet, I wonder what is wrong.

And, like Mr. Albuck said, the low levels that could not be detected by the 256 kits, even—I mean that much exposure at low levels for 40 some days still will add up.

And these alarms, you know, they were not a figment of our imagination. It caused total chaos in our base camps when they would go off, and there is a reason why we were in our chemical suits for 45 minutes to 2 hours before the "all clear" signal was given. They know there was chemicals in the air.

I became good friends with the colonel that I drove for. We spent a lot of time together and this man shared very important information with me, and that is why I have decided that I need to say something, because I wasn't a colonel in the Army but I was with a colonel in the Army, and the man was, he was fantastic to me and the rest of our battalion. And I know that these things happened and nobody can change my mind of this.

Mr. EVANS. Kimo Hollingsworth.

Mr. HOLLINGSWORTH. Yes, sir. Our alarms were constantly going off, also. The problem we face is that our alarms were kept at the battalion level, so what type of checks they did after that I cannot

tell you. I can tell you, though, that generally speaking your paper is only going to detect one or two types of chemicals that may be in the air, and if there is a cocktail mix, which Soviet doctrine specifically talks about, you won't be able to detect that.

Mr. EVANS. Which suggests another question about the alarms and that is just how reliable these alarms were. If I understand it, Troy, you are saying that there is a lower threshold for the A1, and that may be there is a higher threshold for the 256 kits?

Mr. TROY ALBUCK. That is my suspicion. You know, we use the M8 chemical alarm just as a matter of course during our training, and I have had that chemical alarm go off in Fort Bragg, NC. So the reliability of it is backed up by redundant systems.

The redundant systems include the wearing of M9 paper on your uniform to detect liquid agents, the using of the 256 kit after a chemical alarm to detect what agents are present, and then how to react from that by the 256 kit.

Mr. EVANS. If the M8A1 chemical agent alarms were so routine and were commonly false positives, does that mean that these alarms are unreliable?

Mr. TROY ALBUCK. No, sir. I believe they are reliable, but with everything that, you know, the Army considers reliable we use a redundant system, whether it is communications—we had a triple redundant system with communications. Okay? Because we didn't have the nice array Racal-Motorola radios that the Iraqis had. We had our regular whatever we get radios.

So, with everything you do in the military it is intelligent to use redundant systems. The redundant systems that were used in the chemical situation were the M9 paper, the M8 chemical alarm, the M256 kit, and a heavy dose of common sense, and what we had been trained with, you know, to detect those symptoms personal, you know like excessive flow of saliva, headache, difficulty breathing, constriction of the chest, twitching of exposed muscular or exposed skin areas, whatever the case may be.

I didn't experience those. The 256 kit didn't show anything. Nothing on the M9 paper, while the M8 chemical alarm got something that was so low it was not going to affect us, so let's get out of MOPP gear before we die of sweating to death.

Mr. EVANS. The agents disperse rather quickly, so you would use the 256 kit test almost immediately?

Mr. TROY ALBUCK. Yes, sir. As a lieutenant, I had one of my ammo pouches without ammo. Essentially, it was 256 kits. My concern for the chemical war was pretty high, and looking through my notes that I kept at that time, which I just got out like a week ago going through my rucksack and whatever, I had written down exactly what was told to us about chemicals.

We were told that there was a better than 50 percent chance that chemicals would be used. We were told that the delay in going across the border was to wait for the stuff to lose effectiveness. We were told not to go near any FROG or artillery positions that had been destroyed. The reasoning for that was that if there were chemical munitions prepositioned at those locations that they would have spilled onto the desert from the air attack during their destruction. So, to avoid those altogether, and less contamination.

I think that there was not an understanding at that time of the cumulative effect of low levels of nonlethal exposure to chemical weapons. I believe that chemical weapons nonlethal exposure over a period of time gave us a cumulative dose. Enough that damage was done to ourselves that is now being evidenced.

Mr. EVANS. Mr. Martin needs to be excused to go to the Senate side, unless my colleagues quickly had a question.

Mr. BACHUS. I have got one.

Mr. EVANS. We have questions for Mr. Martin.

Mr. BACHUS. I have one. Did you see any dead animals or plant life?

Mr. MARTIN. There wasn't very much plant life over there. But I have seen—I have got a lot of pictures of dead animals, and I have seen a lot of dead animals.

Mr. BACHUS. What was your—I mean describe that to me in some detail? I mean were these whole herds of animals dead?

Mr. MARTIN. Mainly the sheep. I saw herds of sheep that were dead. Camels were an individual basis, maybe. Maybe two, maybe three together at once. Because I didn't see herds of camels. I only seen, maybe, a half a dozen running together at a time at any one time. But most of the sheep that I seen dead were large herds of sheep, anywhere from 10 to 25, 30 sheep, I would see scattered.

Mr. BACHUS. When you first got there were these herds there and healthy, and then at some point they started all dying? Would you see a herd when you were moving around?

Mr. MARTIN. Well, like I said, sir——

Mr. BACHUS. I am trying to get a picture in my mind.

Mr. MARTIN. In the miles that I traveled along Tapline Road, which was a main access road along the border, or up northern Saudi Arabia, came up the side and up north, I got to notice a lot of area. I seen it a lot.

And it's like if you would notice a landmark in your city, and you notice the next day you drive by something is different with it. Maybe they took a banner down or added a banner. Yes, I made a lot of mental notes about different things that I seen.

And we would even—I would have to stop my Humvee on many occasions to let herds go across the street, and it seemed like a perfectly normal area. A day or two later I would come by and there would be dead animals on the side of the road. And the most that I can remember was the incident in Hafar al Batin.

And like I said, I think that is why I took pictures, because it was so different from what I had seen before. There was no dead animals there prior to that and when I came back through they were everywhere. And I do, I got out and I have a picture of me standing by these dead animals. Because I just—it was fascinating that they just lay there like that. Nobody ever tries to pick them up or clean them up or police them up. They just leave them there.

Mr. BACHUS. Kimo Hollingsworth.

Mr. HOLLINGSWORTH. Yes, sir. I would like to add that there were many dead animals. One of the things my unit took notice to, a lot of the marines there, is that generally when you have dead carcasses lying around there is a lot of flies and insects. We observed that there were no flies and insects around these dead animals. We grew a little bit suspicious of that.

Mr. EVANS. Mr. Martin, you are excused. We appreciate your testimony and your coming forward before us today, and I wish you Godspeed over on the Senate side.

Mr. MARTIN. Thank you, sir.

Mr. EVANS. Dennis, we will now ask you to proceed with your statement.

STATEMENT OF DENNIS CULLINAN

Mr. CULLINAN. Thank you very much, Mr. Chairman. And thank you for your consideration in allowing our witness to head on over to the Senate.

As I mentioned earlier, I was really here just to introduce Mr. Martin. I will be very brief in my remarks.

On behalf of the 2.2 million men and women of the Veterans of Foreign Wars, I wish to express our deep appreciation for your ongoing leadership and for conducting today's most important oversight hearing.

As you know, the VFW is absolutely adamant that those who served in the Persian Gulf War not suffer the same neglect and denial with respect to the government's properly caring for their special service-connected disabilities as did their brother veterans of the Vietnam War.

Mr. Chairman, the VFW is very disturbed in the face of the fact that literally multiple thousands of Persian Gulf veterans are suffering from a multitude of ill health symptoms, a government agency, the Department of Defense, namely, is stonewalling. They seem to be doing everything in their power to suggest that there is no problem. Business as usual. This, in our view, is an absolute outrage.

While there are, in fact, a multitude of theories about why these veterans are suffering or what they are suffering from, everything from burning oil wells to parasites in the sand to depleted uranium to Iraqi poison gas attacks, the bottom line issue in our view has to remain the fact that these veterans are suffering from disabilities. They have been sickened in the service of their Nation and they need and deserve help today.

With that I will conclude my statement, Mr. Chairman.

[The prepared statement of Mr. Cullinan appears at p. 176.]

Mr. EVANS. Thank you, Dennis.

Kimo Hollingsworth.

STATEMENT OF KIMO S. HOLLINGSWORTH

Mr. HOLLINGSWORTH. Mr. Chairman, The American Legion wants to thank you and the committee for taking the time to conduct yet another hearing on this emotional and sensitive issue. We would also like to express sincere appreciation to Congressman Kennedy and his staff for putting together a hearing on November 9 that covered some of these same issues.

In June, The American Legion testified before this committee concerning health issues of Persian Gulf veterans. As a result of that hearing the House put together legislation, that ultimately passed the House, to provide priority health care to Persian Gulf veterans. The American Legion and American veterans thank the

committee for their swift action. There is a similar bill in the Senate, and we can only hope that they will take swift action.

Mr. Chairman, since that hearing the number of names on the VA's Persian Gulf Registry has more than tripled. And finally, as a result of last week's DOD briefing, DOD has finally come forth and admitted that not only hundreds, but possibly thousands, of active duty personnel are ill. The American Legion is pleased in that acknowledgement because the problems are not only limited to National Guard and Reserve units.

The Legion is also pleased with the proactive position that the VA has taken with their measures down in Tuskegee, AL, and we hope that they can continue to march forward in that regard.

Legion representatives attended a DOD press conference on 10 November and we were terribly disappointed with the explanation of the chemical detection reports by the Czech chemical teams. Until recently, DOD adamantly denied exposure or any reports of exposure to both chemical or biological agents.

The Legion felt that the press conference produced half truths and understatements as to the degree of exposure of coalition forces to chemical agents. The issue of possible exposure to biological agents was never addressed.

The practice of mixing chemical and biological agents is a known delivery technique of Soviet doctrine. With the presence of chemicals now being acknowledged by DOD, the possible presence of biological agents must now also be addressed.

Mr. Chairman, based on research and practical experience I can tell you that when you check for radiation you can find it in the combat environment with a RAD meter or a Geiger counter. For chemical agents, you can readily test with M8 paper or M251 detection kits. However, the inability of a person to detect biological agents on a combat battlefield is nonexistent. Detection must be done or performed in a laboratory.

Mr. Chairman, the Marine Corps Institute's Command and Staff College for the Nonresident Program Section 5 addresses Nuclear and Chemical Operations specifically discusses aspects of biological warfare. I would like to read a couple quotes from that DOD manual.

"Biological agents can't be detected by the human senses. A person could become a casualty before he is aware that he has been exposed to a biological agent. An aerosol or a mist of biological agent is borne in the air. It moves with the air currents and can enter buildings and fortifications. These agents can silently and effectively attack man, animals, plants, and in some cases, material."

It also states that "It is likely that agents will be used in combinations so that the disease symptoms will confuse diagnosis and interfere with proper treatment." Gentlemen, the symptoms reported by Persian Gulf veterans today have clearly confused most doctors and have defied almost all treatments.

Additionally, the text states that "The microorganisms of possible use in warfare are found in four naturally occurring groups—the fungi, bacteria, rickettsiae, and viruses. The fungi range from single cell, such as yeast, to multicellular forms, such as mushrooms and puffballs. The bacteria may occur in varying shapes, such as rods, spheres and spirals, but are all one-celled plants."

I want to remind this subcommittee of the testimony presented by Dr. Edward Hyman last June. To date, Dr. Hyman has successfully treated nine Persian Gulf veterans and three of their spouses. His research has found that all 12 patients have had in their urines bacterias the shape of spheres and also the presence of yeast, which would indicate a fungus.

Referring back to the Marine text: "In field trials using harmless biological aerosols area coverage of thousands of square miles have been accomplished. The aerosol particles were carried long distances by air currents."

Prior to the ground war, American and Allied aircraft consistently bombed chemical and biological ammunition stockpiles. As a Marine who participated in the Persian Gulf War from January through May, I give you firsthand testimony that the wind direction was predominantly in a southerly direction.

In reviewing military health records from returning Gulf veterans, The American Legion has noticed a form used by health care providers that question personnel about the possible exposure to environmental hazards, specifically chemical or biological exposures. Many questions on that form perfectly match the symptoms being reported by Persian Gulf War veterans. This form clearly indicates that DOD had anticipated these symptoms.

Sir, I have a copy of that form here with me today, and during the question-and-answer period, I would be more than happy to run down a list of questions that have been asked of Persian Gulf veterans.

The American Legion believes that the United States intelligence agencies are withholding valuable information that could play a critical role in finding the cause and cure for medical problems by Persian Gulf veterans. The American Legion continues to urge Congress, the VA and DOD to conduct a full epidemiological study on the health care issue of Persian Gulf service.

Mr. Chairman, that concludes my testimony.

[The prepared statement of Mr. Hollingsworth appears at p. 179.]

Mr. EVANS. Kimo, thank you. The questionnaire that you have offered will be entered into record of the hearing.

Mr. HOLLINGSWORTH. Yes, sir.

Mr. EVANS. We have one more witness before we go to questions. Mr. Kreidler, do you have a statement you would like to make?

Mr. KREIDLER. I would just like to ask unanimous consent to submit an opening statement.

[The prepared statement of Congressman Kreidler appears at p. 104.]

Mr. EVANS. Without objection, so ordered.

Mr. KREIDLER. Thank you, Mr. Chairman.

Mr. EVANS. Mr. Egan.

STATEMENT OF PAUL S. EGAN

Mr. EGAN. Thank you, Mr. Chairman.

The testimony here this morning is incredible. Unfortunately, it sounds all too familiar.

We have a rather long and inglorious history in this country of treating those having served in military situations and who have been exposed to a variety of different kinds of agents as if they

were never exposed; that they have never run into problems; that everything is fine; and now we are even hearing that they are being told that all their problems are somehow psychiatric or related to post-traumatic stress.

By the time veterans exposed to ionizing radiation during experiments were finally compensated for any of their disabilities, many of them, if not most of them, had already died. We are only now within a couple of months of resolving the experiments using mustard gas a long, long time ago. Agent Orange took 13 years before we finally got the first compensation bill, and that was in February of 1991, thanks to your efforts. And now here we have Persian Gulf syndrome.

Much of the problems with the Agent Orange exposure and finally getting to a point where there was a reasonably decent acceptance of the fact that Agent Orange causes damage results from the fact that we have relied on government agencies to carry out science, and agencies carrying out the science with a policy agenda other than getting at the facts, getting at the truth.

These are lessons from the Agent Orange issue, an issue that is not over by any stretch of the imagination. We have now a Gulf Registry. We had an Agent Orange Registry, which still is in existence, but is there anyone to ensure the integrity of that Registry.

Medical exams were given to individuals exposed to Agent Orange, but no one really assured the integrity of those exams to be sure that testing that was done for Agent Orange exposed individuals was in any way relevant to the symptoms or problems that might ultimately result.

Can we say that the medical exams given to Persian Gulf veterans are any better? I am not sure what the answer to that is, but I don't think there is anybody that has really made it their business to ensure the integrity of that work.

In order to avoid the extraordinary delays that were experienced and continue to be experienced by those individuals exposed to Agent Orange, it has to be assumed that chemical and biological agents were used and that individuals in the Persian Gulf were exposed to them. It has to be assumed that individuals in the Persian Gulf were exposed to multiple chemicals resulting from oil fires, medications issued, and a host of other indigenous exposures.

We have to avoid wasting time and to determine that in fact we can go ahead and compensate diseases if there is a reasonable association between exposure and disease. And we, perhaps most importantly, have to come to the conclusion that the Federal Government is inherently untrustworthy in reaching conclusions and in reaching the facts about the damages done as a result of these exposures.

I have a few suggestions for you as a way of, perhaps, providing a road map for getting at some of the answers. I might add, Mr. Kennedy, you asked some questions of OTA and, incredibly, it sounded like deja vu. I mean, as far as we are concerned, Vietnam veterans and those exposed to Agent Orange, OTA has not particularly played a helpful role here. Just today you asked the question, or somebody asked the question, and the response is essentially that looking at chemical and biological exposure wasn't in their job description.

We believe that a model can be fashioned on the basis of the experience that we have seen with the success of the National Academy of Science and its report. Not its science, but its report of a review of the science that has been done on Agent Orange. It is a nongovernmental entity, and lo and behold, in July when it released its report it was trustworthy and it, in fact, drew some conclusions about diseases that are reasonably associated with exposure. The same thing needs to be done again.

There is an entity that needs to be contracted for to do that work. Another entity needs to be established to determine what kinds of epidemiological studies need to be done, and those studies need to be done by nongovernmental entities.

We need to find a way to take out of the hands of the government and put into the hands of a nongovernmental entity responsibility for assuring the integrity of the Registry, ensuring the integrity of the exams that are done, and ensuring the integrity of the assembly of the data that arises from the scientific inquiry.

Some kind of entity needs on that basis to make recommendations, just as the NAS did for Agent Orange exposed veterans, on what diseases bear a reasonable association to exposure. Health care needs to be available, needs to continue to be available through the VA and unhesitatingly so.

And finally, as part of this we need to find a way to create, perhaps, a quasi-governmental entity, something akin to a scientific inspector general operation with broad-ranging subpoena and prosecutorial authority to assure that Federal agencies are coming forward with the information that, in our experience, the Vietnam veterans' experience, government agencies were not willing to come forward with.

And finally, there should be someone to head up this entire operation, and that person should be someone, perhaps, most appropriately appointed by the President with Senate confirmation, so as to assure there is a proper oversight process to offer the best likelihood the individual isn't working for some chemical company or some other proprietary interest with a stake in the outcome of the findings of this operation.

I think it is critically important, Mr. Chairman, as I am well aware that you know, that we find a way to borrow from the lessons of the Agent Orange and previous exposure-type experience so that a resolution can be facilitated and so that we can avoid the extraordinary, and I submit unnecessary, delays that might yet befall the victims of the Persian Gulf War.

[The prepared statement of Mr. Egan appears at p. 184.]

Mr. EVANS. All right, Paul, thank you very much.

Troy, you reported to Houston a week ago yesterday, is that correct?

Mr. TROY ALBUCK. Yes, sir.

Mr. EVANS. I take it by your remarks that you are thinking about not going back?

Mr. TROY ALBUCK. From the person that was introduced to me as the renowned expert the response, ultimately after filling out a questionnaire and going through a question-and-answer period, was that there is really nothing that can be done for us in any case. The testing that is being done, the next thing on the line is

a sleep study and that should basically take care of all the things they were going to do with me.

I am pretty well convinced that a sleep study is not going to get anything more than the multiple psychological evaluations that I have had to endure. So, the need to fly all the way back down there and probably spend another week to get that done seems to be just too much at this point.

Though, I would like to say that everyone I have come in contact with in the VA has been willing to try. They just don't have any direction. And I only just became aware that the VA was, you know, started in 1865 by Abraham Lincoln and that it is supposed to be for everyone. And I am really disappointed that they have never taken on that aspect of their mission.

The way I see it, they were supposed to bind the Nation's wounds. Well, that's easy to say. I mean, we are here for life, liberty and the pursuit of happiness. What if we only got life and liberty? That is the way I see it.

Mr. EVANS. Tim, or Kimo, have you thought about going through the VA program? Have you participated in the Registry itself?

Mr. STRILEY. Yes, sir. And I would like to note that I didn't know about the Registry until I joined a private support group. There was no letter in the mail, no nothing. I had even been to the VA and no one said anything about the Gulf War Registry.

Mr. HOLLINGSWORTH. Mr. Chairman, I did participate in the Gulf War Registry. And I will tell you that the VA in Washington, DC, was very professional and they were very expedient in dealing with me.

However, in the beginning of August, I filed a claim with the VA and it is lost and it is nowhere to be found.

Mr. EVANS. You filed a claim?

Mr. HOLLINGSWORTH. I filed a claim with the VA in early August and there is no record of it any where, sir.

Mr. EVANS. Have any other records been lost by the military?

Mrs. KELLI ALBUCK. I have the records right here.

Mr. EVANS. You have the records——

Mrs. KELLI ALBUCK. For when Troy was first put into Persian Gulf Registry.

Mr. EVANS. Go ahead, Mrs. Albuck.

Mrs. KELLI ALBUCK. I would like to read something off of it, if you don't mind. This is for the past just one year.

Mr. EVANS. Would you identify yourself as Kelli Albuck?

Mrs. KELLI ALBUCK. Yes. My name is Kelli Albuck.

Mr. EVANS. Okay.

Mrs. KELLI ALBUCK. It has his diagnosis, his clinical diagnosis noted but not treated after all of this. You know, he has had every kind of test—Persian Gulf syndrome, chronic fatigue syndrome, ruled out multiple stress related to, you know, social stresses.

Mr. EVANS. So, Troy, you are saying that they are trying to help but they didn't have a handle on it? They just don't know what the problems are, I take it.

Mr. TROY ALBUCK. Typically, you can't manage a horse to water, and unfortunately, it seems like everyone is standing around waiting for the word to come down, and that is why the Army has "green tab" leaders. If you had just staff functionaries all waiting

for the word to come down, we wouldn't have an Army. You have to lead. And unfortunately, no one has been given the nod or no one has the motivation or just whatever—the initiative, to go ahead and lead and find answers.

A year ago when I started all I got were blank stares. Now, I am starting to get, you know, "Oh, yes," out of people when we start talking about the symptoms and that sort of thing.

But really the bottom line has been, from Dr. Miller, which I think she was in an earlier hearing, that there is really nothing we can do. The immunologist says, well, it can't be chemicals, if we are giving it to somebody else. It has to be a virus. But how do we go about finding out what that virus is? I am sure it is, you know, a lengthy process for them.

And really, like I said in my initial statement, in order to burden families with this sort of burden as far as medical, which is overwhelming to any family to have to try and take that on—this is just Alex's records for 3 months, and this cost us $245 to get a copy of. I mean that doesn't go into the millions of dollars of medical expenses for real medical care, for symptoms.

We are unable to combat that alone. The only thing we can do is make a sort of a general plea for assistance, and with the numbers of families that I think are going to begin showing up, once we get this out in the open, because the dozens of families that I have spoken to will not admit to being sick, either because they are on active duty and they know that they will then get a hiccup in their career and it will be over because of a need for zero defects in a military career now to be successful because of the money problems.

What we will end up with is people concealing until the last minute that they are sick. By that time they are physically beat. They are financially drained. They are unable to—the help agencies that are out there are unable to deal with the monumental problems that these families are showing up with. That is why I recommended that active duty may be the only way, so we could make these people comfortable either until they die or until we research an answer and get them a solution.

Mr. EVANS. Did you experience some of the previous miscarriages while Troy was still on active duty?

Mr. TROY ALBUCK. No.

Mrs. KELLI ALBUCK. Yes, the first one.

Mr. TROY ALBUCK. Yes, the first one was just prior to leaving active duty, and the second one was right after leaving active duty.

Mr. EVANS. What about the level of care you received through the military hospital system?

Mr. TROY ALBUCK. We don't go to military hospitals.

Mr. EVANS. You did not go to the military hospital?

Mr. TROY ALBUCK. Not if you are smart.

Mr. EVANS. We are getting static from a cabbie or something. Please continue.

Mr. TROY ALBUCK. The best bet is to avoid those generally because of the long wait, not because of the level of care. The people are just as caring, have just as much motivation and desire to help you, but you would run into a wait period that makes, you know—unless it is a real emergency situation where you can get, you

know, emergency treatment. Other than that you don't want to deal with a military or VA facility for clinical care.

Mr. EVANS. One last question. I wanted to ask Mrs. Albuck, did you want to say something else?

Mrs. KELLI ALBUCK. I just wanted to say a lot of the wives and women are having a lot of infections and female problems, and the one problem that I found going to a military hospital, when he was active duty, I was pregnant, and it seemed like there was a lot of children, a lot of women pregnant right after the war.

So, the problem that I had was I had a lot of female problems so I had to seek, go through CHAMPUS, and I still had a lot of problems getting my bills paid through CHAMPUS because there was such a long wait.

I was having this unknown bacterial problem that no one seems to know what it is. I have—my medical records are about this thick as well. Still no one seems to know what is going on. So that is why we sought medical help outside of the military.

Mr. EVANS. Kimo, regarding the form. The Southwest Asia Demobilization-Redeployment Medical Evaluation form, was this something that DOD used to——

Mr. HOLLINGSWORTH. Sir, it is my understanding that not all units but some units were using this form. And with your permission I would like to read some of these questions on here.

Mr. EVANS. Well, my time has expired. Let me quickly just ask the two other vets here, have you seen this form before?

Mr. TROY ALBUCK. I am looking through the form. I know I have never seen that one.

Mr. EVANS. You were never asked.

Tim, have you seen something similar?

Mr. STRILEY. Me either, Mr. Congressman. And other soldiers that were with the 101st Airborne that I have talked to have never seen that thing before. I have talked to other soldiers out of Fort Hood that have had it, though.

Mr. EVANS. Kimo, I will come back to you.

Let me yield to the Congressman from Pennsylvania.

Mr. RIDGE. I remember during the course of my own training that time of the day that, as recruits and even as a training NCO, I knew the young soldiers didn't particularly care for was the biological and chemical training, when they took you in that enclosed room and everyone left one of the masks open just a little bit, and threw in a tear cannister. There is just something about operating in a chemical and biological environment that is intimidating even in terms of training, let alone actually being involved in the theater that you were in.

But during the course of that training you do learn to personally identify. You don't need alarms. You don't need scientists. You learn to personally identify certain physical responses to an unknown agent, which is the alarm that you are trained to respond to.

And I would ask all the veterans if in your experience over there you personally identified in the theater any of these physical symptoms that manifested themselves that were consistent with your training?

Mr. TROY ALBUCK. To go in order, I will start.

Mr. RIDGE. Sure.

Mr. TROY ALBUCK. Sir, that has been one of the most confounding things for me, as I cannot point to a certain incident or event and say that must have been it. So when I finally, you know, started to get really up on what everybody's information is about this, and I read Senator Riegle's report and he talked about the nonlethal dose delivered by air from the bombing of the production facilities, that is the only thing I can point to.

I did not have a response to the pyridostigmine bromide or anthrax inoculations. I did not—and I waited 3 days for the soldiers to take them first. I cheated. But I didn't have a response to that. I didn't have a specific thing that I could point to that said that must have been the chemical attack.

I was in Riyadh guarding King Fahad with the 3rd Brigade of the 82nd in the initial SCUD attacks, and we watched, you know, the SCUDs come into Riyadh. And I have looked in my notes on the SCUD attacks. I had written down the dates, on January 18 and 21 about the attacks on January 17 and 20, and then I had made some notes on the side of that, that I wasn't going to tell the soldiers from the poop meeting about what was going on—to myself—that I had watched two of the SCUDs hit Riyadh just on the other side of the airfield where we were located.

So, I may have been, you know, in the location of the SCUDs at that time, but I do not point to that as a chemical attack in my memory.

Mr. RIDGE. I might add, just as an aside, I noticed in your testimony you enlisted at 17, you were an officer by the time you were 19, and from the basis of your presence and your testimony now I can understand why.

Mr. TROY ALBUCK. I do not have any specific time and date that I can realize. Of course, there are questions about what caused a sudden intestinal illness, diarrhea, vomiting, fevers, the whole 9 yards, and no specific time.

Mr. HOLLINGSWORTH. Sir, our unit, when we started the ground war we engaged in the prep fires for units going into Kuwait. At that time, I was an artilleryman, and we were engaging an Iraqi artillery position. At that time we received what appeared to be an illumination round. We thought at that time that maybe we were being marked for further artillery attacks, because sometimes you can use an illumination round to mark a target. Beyond that—and it was surprising to us that no direct volleys from thereof occurred. Beyond that I don't think there is any one particular incident that I can say.

I will note again that there were numerous dead animals in the area, and I will also note that at some time very shortly after the ground war my entire unit came down with diarrhea, fevers, vomiting. They were dehydrated—things of that nature.

Mr. RIDGE. I merely raised that question to highlight a point. That doesn't necessarily mean that you weren't exposed. It just means that the training that you had or the agent that seems to have adversely affected you and your families was not detectable from the traditional means that we previously employed.

There have been some instances, chronicled by individual veterans, where the alarms went off, and there was the burning sensa-

tion of the eyes, the mouth, the rash, et cetera, almost immediately thereafter, and they evidenced many of the same kinds of physical problems that you have.

So I just use your testimony to highlight the point that the failure for you to personally detect in a combat situation the presence of those agents does not mean that they were not there, because similar symptoms have been detected by others where alarms went off that corroborated that there was something in the air.

And we all know that the bacteriological agent you wouldn't be detecting. You can't detect that through any tests. You have to actually use the science and bring it to the laboratory in order to detect it.

Let me ask the three veterans, if I could—then I want to get back to you, Paul—were you given a discharge physical?

Mr. TROY ALBUCK. Sir, when we returned from the sort of victory block leave we went right into an intensive training cycle. By the time we returned from that intensive training cycle, really the situation for me was that myself and most all of the lieutenants who were about to make captain had pink slips, and by the time we returned from that intensive training cycle those had been sitting in our in-box for several weeks and we had less than 30 days to get out of the military. Just the out-processing, the things that you had to do to out-process take more than 30 days.

Mr. RIDGE. I understand.

Mr. TROY ALBUCK. So, one of the things that I decided not to do was, you know, get my out-processing physical because at the time I was still in fairly good shape.

Mr. RIDGE. Mr. Striley.

Mr. STRILEY. With me, sir, I did have a physical and the problems with the joint problems, the intestinal problems and the eczema, or so-called eczema was noted, (the sores/lesions). And I did at the day of discharge, with that physical, file a claim with the VA and was given 10 percent service connection for that.

Mr. RIDGE. Mr. Hollingsworth.

Mr. HOLLINGSWORTH. I was given an out-processing physical. During that physical I indicated that I was coughing up sputum every morning in chunks. I also indicated that I had a pain in my center chest.

They did a full array of tests on me and they all came up negative, so the doctor concluded at that time that he felt I was perfectly normal.

Mr. RIDGE. All right. Paul, my time has elapsed, so what I am going to do is just get in touch with you. I think your suggestion with regard to the National Academy of Sciences is an excellent one. You know as well as the chairman of this committee everything we went through with Agent Orange, and there one of the complicating factors was that the physical manifestations of exposure did not reveal themselves until much later on—in most instances until much later on, after the soldier was out of the field and out of the Army. Here we have physical manifestations of men and women, and regrettably, tragically, families, either while they are within the field or shortly thereafter. So I think that is a good idea and I will follow up with you.

I just would like to say, Mr. Chairman, you are going to have to forgive me. I do have to leave. These men and their families give very, very compelling testimony again. And, as we go about trying to determine medical causation, because ultimately we can only treat symptoms until we get to the cause, the etiology, but for the time being there is no reason in God's green earth why these men and women and their families shouldn't be given the benefit of the doubt in VA facilities, or elsewhere if they are not acceptable, at the government's expense.

It is pretty clear that we have got a problem here. And if we horse around for the next 13 years, et cetera, dealing with the issue, as we did with Agent Orange, sadly many of these problems are going to take care of themselves and in a manner which should not be, and is not acceptable to you or me or any other American.

I thank you.

Mr. EVANS. I thank the gentleman from Pennsylvania. It is always good to have your expertise as a combat veteran of Vietnam on this committee, and we appreciate your active participation and attendance with the subcommittee.

The gentleman from Illinois.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

First of all, it is really a pleasure to have all of you here today with this testimony. And I would like to specifically say hello to Mr. and Mrs. Albuck. I am happy to see them here again.

And I want to thank them for coming out and taking the time out at the field hearing that we had that the chairman was good enough to hold in Chicago the weekend before last, and it is good to see you again.

I want to commend you, Troy, of course for taking the brave stance that you have and by telling us your story, and I hope that the government demonstrates as much courage and honesty as you have here today.

Troy, I know you spent the last week or so in the Houston Referral Center, and I would just like to ask if it has just been any different than the experiences you have had in the VA hospitals, first of all?

Mr. TROY ALBUCK. It has been different in that they are actually focusing on Persian Gulf syndrome and not, you know, the experience I had in North Chicago, which was primarily out patient for the first year, which was to just go clinic to clinic and look at one symptom at a time and try to come up with an overall answer, which, you know, obviously, there is no way to do that.

A doctor looks at one symptom and tries to say, you know, it is one thing. Another doctor looks at another symptom that is his area of expertise and say it is another. So it is good that they have a referral center, and they have some doctors there that can look at environmental health problems, and they are trying to get the doctors from all the different areas of the human body together to discuss what the thing is.

But one of the themes that I am hearing recurrently is that at this time there is nothing we can do until there is more research. And the reason for that is no one submitted to accepting low levels or nontoxic or nonlethal exposure to chemicals for research purposes, understandably. So they just don't have studies yet com-

pleted about people getting nonlethal exposures to chemicals or biological, or you know, whatever the case may be.

And again, I would like to say that, you know, who cares where it came from or what it was. Let's take care of the families first. Then we will sleuth down what the answer to the whole thing is.

Mr. GUTIERREZ. Troy, what exactly is the diagnosis that they have given you? What do they say your problem is right now?

Mr. TROY ALBUCK. Well, at Houston, they have switched from what they said at North Chicago. At North Chicago they said it is not mental health related, which was the only good news I got. But they ruled out Persian Gulf syndrome and they had ruled out post-traumatic stress. They had ruled out chronic fatigue syndrome, and they just had no answer.

At Houston, they said, Well, this is Persian Gulf syndrome, and so I asked what Persian Gulf syndrome means and what I got is that the word "syndrome" means "the same road," so it is people that have traveled the same road come under a syndrome.

So, in other words, Persian Gulf vets that are sick have Persian Gulf syndrome, and that is all the further they can go. The immunologist says it has to be a virus because families are getting it. The environmental health person says it has to be chemicals because there were so many chemicals there. Or someone else says it has to be the oil fires. Or the radioactive, yes.

In most of the cases we are not showing the evidence of that because our bodies detoxify a lot of those things.

Mr. EVANS. Will the gentleman yield?

Mr. GUTIERREZ. Absolutely, Mr. Chairman.

Mr. EVANS. I thank the gentleman for yielding.

Are they saying it is symptoms or what you were exposed to or both?

Mr. TROY ALBUCK. Well, all they can do right now is focus on the symptoms, and if we want Motrin or if we want Pepto-Bismol or whatever the case may be, now there is a list of symptoms, and if you have a few of them, then you are part of the Persian Gulf syndrome.

And there is a list of 50 symptoms. I don't have all of them. My wife has a symptom entirely different from me. She has pain in the ears that is not related to an ear infection, just sort of a mysterious severe aching and pain in the ears that the doctors can't figure out. I have never had that symptom, though I have some severe sleep pattern changes that she doesn't have.

But we do have some symptoms in common: the red spots, breathing problems and things like that that make us both part of the Persian Gulf syndrome.

Mr. GUTIERREZ. Mr. Chairman, it seems to me it would probably be good—and Mr. Kennedy probably remembers that day because we both questioned the doctors that were here at the hearing about a test. And we had a couple of doctors here who said to us—we asked the simple question, can you give a test? Is there a medical test that beyond any reasonable doubt that we will know, and they said yes.

And we asked them whether they could give us particular information to the committee at that point. So I think it would be good to take a chance and go back to those two doctors and see just

what tests they know of, because they gave us very clear, compelling information that they had a test and they would know whether they had chemical, or whether it was chemical. At least that is the way I remember it.

Mr. EVANS. It might be. We will review the record and we can, perhaps, submit written questions to them in this instance.

Mr. GUTIERREZ. It occurred to me that maybe we could go back just for a second and talk to those. The question was can you figure out whether you are a malingerer or really sick? Is there like a test that you can give? And they said, yes, we can do it. We can give a test.

And there were two doctors, and they were from Massachusetts, if I remember.

Mr. KENNEDY. Yes. I think that was on multiple chemical sensitivity.

Mr. GUTIERREZ. Well, see what we can get and see how many of them we can begin to identify.

Well, thank you, Mr. Kennedy, for clearing that up.

I just want to ask, Troy, just a second, about the economic kinds of problems that you have confronted after leaving the service and that the illness has brought on.

Have you got any compensation from the VA at all? Do you receive any money from the Veterans' Administration.

Mr. TROY ALBUCK. No, sir. I did file a claim. My understanding is that at this time those claims are being summarily denied across the board for environmental health, other than a limited number with leishmaniasis or immediate exposure to the oil fires.

Economically, the things I have encountered are that progressively over the year I physically became less and less reliable as an employee. I took a job with—well, it was the first job that was offered, because I was out of the military very rapidly and didn't want to be on, you know, like unemployment or something like that. So what I did was I took a job with Radio Shack in the manager training program. I stacked up 9 consecutive months as the Manager Trainee of the Month in the Chicago region and then as a manager 4 consecutive months of the top sales gain in one of the smallest Radio Shacks, behind a building behind a garbage dump in Chicago. So I worked very hard.

But during that year it became progressively more difficult to do my level of performance, to the point where I only had two modes: I was at work, I was sick.

And we spent the one day off a week that I would take from bell to bell at the VA hospital doing whatever clinic visit we could get done that week. And we would pack a lunch, the entire family, and go spend our day at the VA trying to get one or the other clinic visit done.

Finally, I just realized my own limitation and quit the job. Tried to get a job that was less hours and less effort, but I was even unreliable in that because I had difficulty getting coherence, you know, before noon. I was having a lot of problems breathing and just trying to do a regular job, so I quit that one too and decided to go into the VA until I got an answer, and that is where I am at now, still searching for an answer.

Mr. GUTIERREZ. Well, let me just—I know my time is up. I just want to say to Tim, I believe you. We have heard a lot of testimony, and I tell you, the members of this committee believe you. We have heard it. We have all discussed it amongst ourselves, and so you should know that. It is not much compensation, but your word is getting out.

And last, Mr. Chairman, back in our State of Illinois, we have got two witnesses from our home State here today who have given very compelling. I would like to enter into the record, given that there are some colleagues of ours back in the State legislature which are going to be conducting hearings tomorrow in the State of Illinois and they have a State task force that is being put together. I would like to enter into the record these documents putting together the resolution and putting together the committee, so people can know that there are some people back home doing the same kind of work.

Mr. EVANS. Without objection, so ordered.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

[The documents follow:]

RESOLUTION ANALYSIS

RESOLUTION HJR 15 ANALYST Ralph Egan (8122) kw

SPONSOR Dart DATE OF INTRODUCTION 3/25/93

COMMITTEE Veterans' Affairs DATE OF ANALYSIS 3/29/93

SYNOPSIS

Provides for the creation of a Joint Task Force on Gulf War Diseases to study the health problems facing returning Gulf War veterans.

ANALYSIS

The resolution establishes a Joint Task Force on Gulf War Diseases to study the health problems facing returning Gulf War veterans.

Provides that the task force will be made up of the Director of the Illinois Department of Veterans' Affairs, two members of the General Assembly and two members of the public appointed by the Leaders of the General Assembly.

The Joint Task Force will complete a study of the health problems facing returning Gulf War veterans and shall report its findings to the Governor, the General Assembly, the U.S. Department of Veterans' Affairs and the Illinois Congressional Delegation by January 1, 1994.

COMMENTS

The Joint Task Force is being set up to study why over 19,000 men and women who served in the Gulf War have manifested medical problems.

LRB8805810CBcb

HOUSE JOINT RESOLUTION [redacted] 15

WHEREAS, Over 19,000 men and women in our military who served in the Gulf War have manifested medical problems from their Gulf War service; and

WHEREAS, These health problems include, but are not limited to, hair loss, extreme fatigue, blood in stool, extreme rashes, nausea, fever, and other symptoms; and

WHEREAS, These medical problems can lead to more serious illnesses and cause severe physical and mental strains; and

WHEREAS, In addition, these problems cause job and family concerns due to disabilities or inabilities to perform; and

WHEREAS, Recent reports in the news media indicate the extent of the problem across the nation for those who served in the Gulf, and documented diseases like brishmaniasis and problems relating to petroleum sensitivity are widespread, verifiable, and appear to be service-connected; and

WHEREAS, The U.S. Department of Veterans Affairs is in the process of evaluating the issue; and

WHEREAS, Our servicemen and servicewomen served this nation admirably and heroically in our magnificent Gulf War victory with our allies, and they deserve appropriate health care and disability benefits; and

WHEREAS, We owe them a commitment to be exhaustive in our research and resolve these issues as soon as possible; and

WHEREAS, It is important that we expedite the solution of this issue in order to prevent a repeat of the difficulties which arose from Agent Orange; therefore be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE EIGHTY-EIGHTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, THE

SENATE CONCURRING HEREIN, that there is created a Joint Task Force on Gulf War Diseases, to consist of the Director of the Illinois Department of Veterans Affairs, ex officio, plus two members of the General Assembly and two members of the public appointed by each of the following officials: the Speaker of the House of Representatives, the President of the Senate, the Minority Leader of the House of Representatives, and the Minority Leader of the Senate; and be it further

RESOLVED, That the Joint Task Force on Gulf War Diseases shall study the health problems facing our returning Gulf War veterans, and shall report its findings and recommendations to the Governor, the General Assembly, the United States Department of Veterans Affairs, and the Illinois Congressional Delegation by January 1, 1994.

Dept. of Public Health.

Forward to Congress.

LRB88058J30CBcbam01

AMENDMENT TO HOUSE JOINT RESOLUTION 15

AMENDMENT NO. ____. Amend House Joint Resolution 15 on page 1, in line 14, by changing "brishmaniasis" to "leishmaniasis"; and

on page 2, by deleting lines 3 and 4, and inserting instead the following:

"Illinois Department of Veterans Affairs, ex officio, plus four members of the House of Representatives, four members of the Senate, and two members of the public".

AMENDMENT ANALYSIS

AMENDMENT 2 TO HJR 15 Dart

OFFERED BY Dart

COMMITTEE Floor

ANALYST Ralph Egan (8122) mm

DATE OF ANALYSIS 4/16/93

BILL SYNOPSIS

Provides for the creation of a Joint Task Force on Gulf War Diseases to study the health problems facing returning Gulf War veterans.

AMENDMENT ANALYSIS

The amendment increases the membership of the Task Force on Gulf War Diseases to 20 members.

The task force will include the following members:

- The Director of the Department of Veterans' Affairs.
- The Director of Public Health.
- Four members of the General Assembly appointed by the Speaker of the House of Representatives.
- Four members of the General Assembly appointed by the President of the Senate.
- Two members of the General Assembly appointed by the House Minority Leader.
- Two members of the General Assembly appointed by the Senate Minority Leader.
- Two members of the public appointed by the Speaker of the House.
- Two members of the public appointed by the President of the Senate.
- One member of the public appointed by the House Minority Leader.
- One member of the public appointed by the Senate Minority Leader.

Mr. STRILEY. Mr. Chairman, I was wondering about that subject myself. I have got other veterans in the Iowa-Wisconsin-Illinois area, let me know when and where and I will have those veterans there. I think we can do something in our area.

Mr. EVANS. We hope you will communicate with our respective staffs about having some of our representatives at these meetings and hearings in the future.

Mr. STRILEY. Yes, sir.

Mr. EVANS. Let me recognize the gentleman from Georgia.

Mr. COLLINS. Thank you, Mr. Chairman.

Just briefly, I find of interest the remarks of Officer Albuck referring to those who are still on active duty and their fear of coming forward with their problems, and I call the chairman's attention to information that I submitted on behalf of Nick Roberts from Columbus, GA, a list of individuals that he has gathered that also have severe health problems.

And in his comments he refers to the fact too that he had a number of other names that he could submit but by request of those people, they were still on active duty and were afraid to come forward. I too would like to submit a list of questions that on August 31 was submitted to the Department of Defense, Secretary of Defense and Department of Navy, questions revolving around chemical warfare that Officer Albuck has answered some of those questions here today.

But I would like to submit this for the record, if there is no objection.

And thank you, Mr. Chairman.

(See p. 109.)

Mr. EVANS. The gentleman from Massachusetts.

Mr. KENNEDY. Thank you, Mr. Chairman.

I wondered, Mr. Hollingsworth, you referred to the Marine Corps Institute Command and Staff College Non- Resident Program on Nuclear and Chemical Operations dealing with some biological agents which states limitations in detecting biological agents. These U.S. military limitations, I assume, are reasonably well known. But we heard testimony some time ago by Dr. Hyman, who I think you are familiar with. Is that correct?

Mr. HOLLINGSWORTH. That is correct. I was treated by Dr. Hyman.

Mr. KENNEDY. Yes. Dr. Hyman in his testimony, as I recall it, not only indicated that there was some kind of germ that he had been able to detect, but he was the first person, although he didn't directly say it, he certainly implied through his answers and through his inflections that he felt that at some point some kind of biological or nerve agent will be uncovered.

I wonder if you could, perhaps, clarify or just talk a little bit about what your sense of Hyman's work is and how it pertains to the recent acknowledgments that there were in fact some small doses of nerve or biological agents present as a result of the Czech study.

Mr. HOLLINGSWORTH. The first thing I want to remind the committee is that, number one, when we talk of chemicals and what the DOD has now acknowledged, that the Czechs did indeed find some chemicals, I just want to point out that with the presence of

chemicals now into play, I can't reiterate enough that now biological agents have to be looked at.

In terms of Dr. Hyman, his research has indicated both a strep and a staph infection, okay? I want to say, and you can contact him because I am not a medical expert. But I want to say that a lot of it hinges on an account developed back in the late fifties by a Dr. Case out of Harvard, and what he basically stated is, there was a caveat in there on the term significant.

In other words, if you have a bacterial count that is less than 100,000, it is not termed significant. Okay?

I have checked this with my doctor here in Rockville and he confirmed to me right out that you should have nothing in your urine, whether it is one strand of bacteria. There should be nothing there.

Mr. KENNEDY. And is there a strand in yours?

Mr. HOLLINGSWORTH. That is correct. I had the opportunity to both look under Dr. Hyman's microscope and to see a growth that he produced out of my urine which was a strep and a staph infection.

Mr. KENNEDY. And was there anything that led you to believe that that was anything other than a strep germ that might be carried by a number of people in this room?

Mr. HOLLINGSWORTH. No. Well, actually there are two parts to that question. Not initially. I will say that now yes, and the reason being is that Hyman has treated nine veterans and three dependents. Okay? And I can't reiterate enough that all nine veterans and all three dependents have shown the same types of things.

His last veteran that he treated was Sterling Simms. He has been to the VA for 2 years for skin conditions of which they kept giving ointments and pills and he did not get better. He had a 4-hour visit with Dr. Hyman, was given some drugs and he is 90 percent better now.

Mr. KENNEDY. I appreciate that, and I am not trying to make you answer questions that would be much more appropriate to be answered by Dr. Hyman. I am just trying to get to whether or not this new admission that there were in fact some kind of chemical agent present in the Persian Gulf pertains in anyway to the kind of presumptions that Dr. Hyman has as to what the cause of these strep and other bacteria that are found in the veterans that he has treated might be.

Mr. HOLLINGSWORTH. First, let me state that I can't reiterate enough that Soviet doctrine calls for a cocktail mix. If there has been admission to low level chemicals in the Persian Gulf, they need to do a full epidemiological study to look at the biological aspects also. Okay?

Mr. KENNEDY. Okay. In terms—yes?

Mr. HOLLINGSWORTH. The next thing I want to say is that, number one, I am not sitting here and insinuating that biological agents were used in the Persian Gulf. There very well could have been a bacteria that is present in Saudi Arabia, Kuwait, or Iraq that we Americans are not used to.

These things could have come from allied bombing. The winds were blowing in a southerly direction. For all we know, there could have been a chemical such as a nerve agent or mustard based agent that weakened the immune systems to make us susceptible

to these things. I don't know. But we need to do a study in this area.

Mr. KENNEDY. Thank you very much, Mr. Chairman.

We have asked, and Chairman Evans and others on this committee have asked that we look into Dr. Hyman's work. I think at our, in a hearing, I don't know how long ago that hearing was——

Mr. HOLLINGSWORTH. June 9th.

Mr. KENNEDY. June 9th—thank you very much—we asked General Blanck, who is going to be testifying in a little while, to look into the potential of linkages between Dr. Hyman's work and these potential exposures. My understanding is that that was supposed to get back to us in October. I am just told that that has now been delayed at least until December. So I think it is important to try to continue to have the DOD and VA look into this possible linkage and try to get to the bottom of it.

Mr. HOLLINGSWORTH. I think DOD is fully aware of it. And let me state this. That last week Les Aspin stated that he was going to assign Joshua Lederberg to head a committee to investigate Persian Gulf syndrome. Dr. Lederberg is a bacteriologist. He won the Nobel Prize in 1958 for genetics with bacteria. I find that a very strange coincidence.

Mr. KENNEDY. Are you happy with that?

Mr. HOLLINGSWORTH. I am very happy with that. The problem I have is that once again we feel that the DOD is not producing all the truth. We think there needs——

Mr. KENNEDY. Why is that? I am having a hard time following you. If Deutsch has appointed this fellow who you are happy with, what indicates that you feel that they aren't doing a good job.

Mr. HOLLINGSWORTH. Mr. Kennedy, I can't reiterate enough that until recently the DOD adamantly denied any presence of chemicals in the Gulf.

Mr. KENNEDY. Fair enough. Fair enough. Thank you very much, Mr. Chairman.

Thanks, Mr. Chairman.

Mr. EVANS. Thank you.

The gentleman from Alabama, Mr. Bachus.

Mr. BACHUS. Thank you.

Mr. Hollingsworth, are you aware that the Department of Defense appropriation that was just passed appropriated a million point two to Dr. Hyman?

Mr. HOLLINGSWORTH. Yes, sir, I am.

Mr. BACHUS. I don't know whether this committee was aware of this fact.

Mr. HOLLINGSWORTH. That came about in a conference report.

Mr. BACHUS. You are aware of that, that that was done?

Mr. HOLLINGSWORTH. It would be interesting to note also that depleted uranium studies and the multiple chemical sensitivity studies got reduced.

Mr. BACHUS. I don't know whether you are aware of it, but I am from Alabama and Sterling Simms and several others. We have been communicating with them and with Dr. Hyman for some 2 or 3 months, and I am on the same side of this issue as you are.

Mr. HOLLINGSWORTH. Yes, sir.

Mr. BACHUS. I am not in any way an adversary, but I think it will enable him more with the promising work he is doing simply from the fact that I have several veterans from my district who he has treated successfully. So I think it is going to be interesting to see where that work leads. But he now has an appropriation of a considerable amount of money.

Mr. HOLLINGSWORTH. Once again I can't reiterate the fact that with the acknowledgment of chemicals in the Gulf a full epidemiological study needs to be addressed. Until recently, the word chemical and biological issues was not addressed in terms of agents. It just wasn't addressed.

And, you know, the June 9 hearing, that was 6 months ago. Why the delay? We need to address these issues with also multiple chemical sensitivities and antibiotics or whatever we were given, the shots that we were given. The whole slew needs to be looked at, and that hasn't happened to date. It has been very narrowly focused.

Mr. BACHUS. I agree. I am just saying that I think this Oversight Committee has been the very committee here in the House that has demanded that we do this, and Mr. Browder has pursued the question of whether our troops were exposed to chemicals.

You have got to understand that not only you but this committee, was told the Pentagon, and the Pentagon position has always been that there was no evidence of exposure to chemical agents, that the chemical sensory alarms didn't go off, that in the whole Persian Gulf theater not one allied unit ever reported a possible exposure to chemical warfare.

Now, we find out, in the last month or so, that these alarms, according to testimony we heard today, these chemical sensory alarms went off on maybe a daily basis.

So, that is one possible explanation for why we have not made any headway. You have been told the same thing we have been told, and I think, for one thing, that delays us in considering biological warfare, because we know Saddam Hussein has practiced chemical warfare and biological warfare in the past, but we knew that if in fact it had happened in the Gulf War that there would have been a detection at some point, and we were told that there weren't any.

Mr. HOLLINGSWORTH. Mr. Bachus, I would like to say that I disagree with you on one point. First, we have not had a lot of delays in dealing with this issue. I once again can't thank Lane Evans and the full committee here for the actions they have taken. Okay? We have been moving along. It has gone slowly, but we have been moving along.

I bring back to the attention of H.R. 2535. I can't compliment this committee enough for taking such swift action on that. We need to get legislation out of the Senate now that is going to do the same and we need to continue on with the process. The key point is that we don't have 10 years to conduct an investigation. Veterans are dying now, and their families are being affected.

Mr. BACHUS. I say, Kimo, that we agree with you. I guess what I am saying is I am somewhat frustrated over the fact that the Pentagon has told us there was no evidence of any exposure by our troops to chemical warfare, and if we had been told that early on

I think we would have pursued that inquiry from day one and we would have considered whether there was biological warfare, and that issue would be as far along as some of these other issues which we have investigated.

Mr. TROY ALBUCK. Excuse me. Could I say something, just real briefly? I think that the way we asked the question of the Pentagon as far as were there chemical exposures, in my experience when the M8 chemical alarm went off and we did the 256 test and we got a negative response from that, well, that's not a chemical exposure.

And I imagine that in most instances where the M8 chemical alarms went off, even on a daily basis, if those tests came up negative at that time there was not a chemical exposure.

I think that is why we might have gotten a response from, you know, whoever the big-wigs are at the Pentagon or the Army or wherever that say, "No, no chemicals." But down at our level we were getting, you know, sort of a mixed—you know, we were getting chemical alarms but we weren't reading any agents.

Mr. BACHUS. But you know, I wonder. If these alarms were going off as often as we have heard testimony that they were, then either they are false alarms, and there is something wrong with the detectors, or—is that not at least evidence that something is in the air?

Mr. TROY ALBUCK. This may sound like a really funny analogy, but I think it fits. It is like missing a period and then you do the little dip test and you get a negative, you are not pregnant. When you are on the ground at that time it seemed like it was an all or nothing thing. You are not half pregnant.

But now it turns out that there is sort of a case in the—you know, that is where the analogy breaks down—that you can be, and that is that we got a nonlethal dose with a cumulative effect over weeks or months, whatever the case may be depending on the unit's deployment time where we are now, you know, experiencing symptoms from damage that was done by either chemicals or by a virus or bacteria that we are carrying.

Mr. HOLLINGSWORTH. I think the important thing here, sir, is that there has been no formal studies done on low level exposures to both chemical or biological agents.

Mr. BACHUS. There have been in pesticides.

Mr. HOLLINGSWORTH. That is correct.

Mr. BACHUS. Which is—and this is some of the same agent.

Mr. STRILEY. Sir, I find it interesting to note also, if I could, that I have been in dealings with Dr. Hyman myself and he has sent me a urinalysis kit. I sent my samples to him and he found the same thing that he found in Mr. Hollingsworth here.

Dr. Hyman talked to me over the phone, making no promises or diagnosis, and then sent a urinalysis kit. It took weeks for the results. But yet, a VA doctor talks to me over the phone, asks me questions—are you having this, this, this and this—well, she diagnoses me over the phone as having multiple chemical sensitivity. My doctors, my civilian doctors have told me that is a quack. Any physician that diagnoses a person over the phone is unproffessional and could be considered a quack. This doctor works for the VA.

Dr. Hyman is someone who is here to help us, and the VA it seems like, with this particular person anyway, doesn't want to help.

Mr. EGAN. Mr. Bachus, I would like to just, you know, make a point of clarification here. I think history sometimes is useful on these things. When you pursued the line of questioning about the fact that the Pentagon hasn't told the Congress that chemical agents were used, or perhaps biological agents, or perhaps in some sort of a cocktail combination, I have personally sat through hearings both in front of this committee as well as the Senate Committee on Veterans Affairs where the topic was the individuals exposed to ionizing radiation during a nuclear test in the fifties, and the Department of Defense consistently said, well, everything was fine. We have the soldiers that were exposed, we had them wearing badges. And lo and behold, there wasn't any indication on the badges that anybody had received any dosages of low level or high level radiation.

Well, later it turns out that many of these badges were defective, perhaps deliberately so. And then you come to find that some of the individuals were wearing badgers that had lit up like a stoplight.

So, for policy purposes here, if you assume Soviet military doctrine requires or suggests using chemical and biological agents, and if you further assume Saddam Hussein was following pretty closely the Soviet military doctrine, you have to conclude that our military personnel deployed in the Middle East were exposed.

Then you have to determine what it is those exposures cause, and then you have to begin the business of providing disability compensation for those things. It is not surprising that the Department of Defense has dragged its feet in bringing the truth forward.

Mr. HOLLINGSWORTH. Sir, I just want to add to that, that once again I want to reiterate I think we are heading in the right direction, and don't misinterpret me. I am not implying that DOD is lying. I think there is a lot of information out there that they are not releasing. Okay? And I think that we need to get that information because it is going to be critical in determining both the cause and a cure.

Mr. EVANS. I believe it is frustrating to Members of Congress, and it must be agonizing to the veterans themselves. We have been very much aided by the other gentleman from Alabama in doing that, and I would like to recognize him at this time, Glen Browder.

Mr. BROWDER. Thank you, Mr. Chairman. I appreciate the opportunity to participate on this subcommittee, although I am not on the Veterans' Affairs Committee.

I would like to just, I guess, put in a motion here that we orient ourselves toward the target that we are chasing. I hear the hounds barking and they are on the right track and they are barking up the right tree.

Let me suggest, though, that we not look over here and send the hounds off in the direction of another tree—and that is DOD. We are on their trail. If we have to, we will take that building apart brick by brick and put it back together to get their attention to chemical and biological agents in defense.

I have been in Congress since 1989. We have had legislation introduced trying to get them to do so, or recommending it. Last

night, we passed a conference report on the defense authorization bill which gives specific direction.

Some people can call it micromanagement, which we don't like to do. But when somebody is not doing something right, Congress will manage it. If we have to pass that kind of legislation, we will do it, and we are doing it this year. We are going to get them on track with this legislation on chemical and biological warfare and defending our military personnel against it.

I believe that in these hearings and Armed Services Committee hearings and Senate hearings, we are going to nail down that chemical and biological defense has not been that high a priority with the Defense Department. We think that they did not give us adequate information in response to our questions about whether there was exposure. But that is, frankly, a question that we are going to get at in other hearings and some here today.

But I think you are right. We have got people out there, Gulf War veterans, who are sick and dying, and we intend to get to the bottom of it and get them help at the same time that we are going after the Department of Defense to acknowledge the chemical and biological threat, and the fact that they need to be more responsive to us and to our veterans and active military personnel on this issue.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you very much.

Kimo, I said I would ask you to comment on the questionnaire.

Mr. HOLLINGSWORTH. Sir, I would just like to run down a list of questions. I want to let the committee know it is my understanding that Senator Riegle's office has the official copy of this, the true form. This is a copy. Okay?

This is called a Southwest Asia Demobilization/Redeployment Medical Evaluation.

Question number one reads: What diseases or injuries did you have while in the Southwest Asia region?

Question number two: Are you receiving any medicine or other treatment at the present time?

Question number three: Do you have fever, fatigue, weight loss or yellow jaundice?

Question number four: Do you have any swelling of lymph nodes, stomach or other body parts?

Question number five: Do you have any rash, skin infection or sores?

Question number six: Do you have a cough or a sinus infection?

Question number seven: Do you have a stomach or belly pain, nausea, diarrhea or bloody bowel movements?

Question number 8: Do you have any urinary problems such as blood or stones in the urine or pain and burning with urination?

Question number nine: Have you had any nightmares or trouble sleeping?

Question number ten: Have you had recurring thoughts about your experiences during Desert Shield/Storm?

And question number eleven: Do you have reason to believe that you or any members of your unit were exposed to chemical warfare or germ warfare?

Mr. Chairman, clearly these, and I am not implying that DOD is covering up again, but it seems to me that they may have been anticipating some things. And I can only say that this needs to be fully investigated also.

Mr. EVANS. And we intend to ask them about it when they testify today.

We have no other questions. Thank you for your long and lengthy testimony here today and your service to our country. We really appreciate you stepping forward. We know it is not easy. And we know we can count on you in the future to help us with more questions that need to be answered.

We thank the veterans service organizations as well. This panel is now dismissed.

Mr. EVANS. Members of our next witness panel are two VA physicians who examine Persian Gulf veterans. Dr. Myra Shayevitz is Director, Cardiopulmonary Laboratory, Pulmonary Rehabilitation Program at the VA Medical Center in Northampton, Massachusetts. Dr. Charles Jackson is an Environmental Physician and Staff Physician at the VA Medical Center at Tuskegee, AL.

Dr. Shayevitz, we will proceed with you once you are situated.

STATEMENTS OF DR. MYRA B. SHAYEVITZ, DIRECTOR, CARDIO-PULMONARY LABORATORY, PULMONARY REHABILITATION PROGRAM, VA MEDICAL CENTER, NORTHAMPTON, MA; AND DR. CHARLES JACKSON, ENVIRONMENTAL PHYSICIAN, STAFF PHYSICIAN, VA MEDICAL CENTER, TUSKEGEE, AL

STATEMENT OF DR. MYRA B. SHAYEVITZ

Dr. SHAYEVITZ. I first became acquainted with the multiple chemical sensitivity syndrome when I myself became incapacitated from MCS in 1989. About a year ago, I was casually reading about the mysterious Gulf War syndrome and there before me were symptoms I recognized all too well.

The majority of cases of MCS begin with a combination of stress, a petrochemical and/or pesticide exposure, and therefore the unique circumstances and exposures of the Desert Storm conflict may well have resulted in MCS in susceptible individuals.

Another important feature of the illness is that subsequent disabling symptoms are triggered by very low levels of unrelated chemicals in common usage. MCS is not limited to veterans of Desert Storm. The diagnosis and treatment of MCS is listed by the Occupational Health Clinic at Massachusetts General Hospital, Emory University School of Public Health, Robert Wood Johnson Medical School, Yale and Johns Hopkins, among other prestigious university clinics.

Now, here are the textbook symptoms of multiple chemical sensitivities syndrome: fatigue, gastrointestinal symptoms, headache, muscle and joint pains, difficulty concentrating, confusion, aching in the chest, eczema, among other symptoms, and here are the symptoms of our veterans supplied to me by Dr. Han Kang, epidemiologist of Veterans' Affairs Central Office: Fatigue, skin rash, headache, loss of memory, muscle and joint pain, shortness of breath, cough, diarrhea, and chest pains. The Desert Storm veter-

ans may not have MCS, but they do have identical symptoms to those with that disorder.

Many of the veterans I have seen are unable to work and have little to no funds. At our Medical Center there is no budget for special testing, organic rotation diets, air purifiers, protective masks, and nutritional supplements. There was insufficient staff available for patient education, psychological support and testing, exercise training, nutritional counseling, an investigation of family and occupational problems, and there is no chemically clean area for patient examination or treatment.

There are many theories being proposed as causative of the illness of the Gulf War veterans. However, it seems to me that the common denominator is the symptoms of this illness itself which clearly approximates those of the multiple chemical sensitivity syndrome about which much is already known and for which a rational and safe therapy exists. This treatment is most effective when accomplished early in the course of the disease.

I maintain that it is absolutely urgent for us to attempt a treatment plan now. We at Northampton VAMC have submitted such a proposal to VA Central Office, based on a 30-day hospital stay in a chemically clean ward with an interdisciplinary team of specialists. We would follow these patients intensely for a minimum of one year with comprehensive biological and psychological testing. We feel that our treatment proposal would be of great benefit and could serve as a pilot program for other such units, and as an educational and training resource.

I would like to read an excerpt from a statement by one of my patients.

After returning from a combat tour in Iraq in April 1991, I began to suffer from several ailments previously uncommon to me. The worst ailment was recurrent severe frontal headache. My weight began to drop from a steady 165 to 140 pounds. Chronic fatigue was the most persistent. I found myself fatigued regardless of the amount of sleep. Also, problems with my short-term memory.

In May of 1993, I underwent a Persian Gulf environmental examination by Dr. Myra Shayevitz. Dr. Shayevitz prescribed vitamins, instructed me to avoid all chemicals and petroleum products. I no longer suffer from chronic fatigue. My current weight is nearly 160 pounds and I haven't experienced a severe headache. On my November 9 visit I reported no problems whatsoever, and I feel that the treatment was wonderfully successful. Glen R. Bono.

In summary, my message is that the Gulf War syndrome is most likely multiple chemical sensitivity and that to prevent permanent injury we need to provide our veterans with treatment now.

I know how very difficult, from personal experience, it is to contend with this syndrome, how very difficult it is to change lifestyle, how terrifying it is not to be able to concentrate, to walk around fatigued with headaches all the time. I was very lucky. I had the finances, I had the social support of a wonderful husband physician, and, in fact, I even have a kindly employer at VA Northampton that makes accommodations for me, and I feel that within the VA I had a unique experience and with that came the singular responsibility to try to step forward and be of help.

And I thank you very much more inviting me here today.

[The prepared statement of Dr. Shayevitz appears at p. 190.]

Mr. EVANS. Thank you, Doctor, very much.

We have a vote pending, and I think it might be wise if we recess until the vote is concluded. It should be about 15 minutes.

[Recess.]

Mr. EVANS. If everyone would please be seated. We would like to reconvene this hearing.

Dr. Jackson, as soon as everyone is seated, we will call on you. We appreciate you coming up from Tuskegee and look forward to your testimony.

You may proceed now.

STATEMENT OF DR. CHARLES JACKSON

Dr. JACKSON. We at Tuskegee VA hospital in Atlanta wish to thank this committee for allowing us to come and speak before it. Basically, I will summarize the written statement that we have here. I think everyone has a copy of the statement, which is a 2-page, typed statement.

We, in August of 1992, at the VA Medical Center in Tuskegee, AL, began enrolling veterans in the Registry.

In view of their complaints about the vaccine, particularly anthrax, that they received in the Gulf, complaints about recurrent diarrhea, joint pains, excessive fatigue, shortness of breath, memory problems and other multiple problems, the VA in Tuskegee deviated from the suggested protocol of a physical examination, CBC, chest x ray, Profile 8, and urinalysis.

In view of the endemic diseases of the Middle East, complaints of diarrhea, joint pain, and exposure to dead animals, which we had gotten comments about from the veterans, the VA in Tuskegee systematically performed an expanded number of tests on the first 100 veterans seen in the Registry. Febrile agglutinins, hepatitis profile, ANA, rheumatoid factor, sedimentation rate, fungal titers and immunoelectrophoresis serum were performed on the first 100 veterans of the Registry.

Where appropriate stool cultures, stools for ovarian parasite and blood culture were performed. All of these tests were basically normal except for what are discussed below.

Finally, by 1993, in September, the VA in Tuskegee had completed data on over 180 individuals. A summary of the results of the 180 individuals in the Tuskegee Registry are these: Number one, of 180 individuals, 28, or 15 percent, had complaints referable to diarrhea or recurrent diarrhea or gastroenteritis problems. Twenty-three, or 13 percent, had complaints of excessive fatigue. Twenty-two or 11 percent of the 180 had complaints of joint pains, particularly fingers and knees, not associated with injury or any prior trauma. Twenty, or 11 percent, had complaints of rash on extremities off and on since the Gulf. Ten, or 6 percent, had complaints of excessive shortness of breath which did not exist prior to the Gulf. Three, or 1 percent, had muscle aches and twitching which did not exist prior to the Gulf.

Most of the people had more than one symptom, and thus there is overlap. A total, however, of the group of 180 people, 63 percent of the group were symptomatic.

Number two: Physical and abnormal findings were found in 26 percent of this group. No individual is in more than one category in this group, thus truly 25 to 26 percent, or in other words, one-fourth of this group of 180 individuals actually have abnormal lab and physical findings which are not usually expected.

Elevated serum protein levels of greater than 8.3 grams occurred in 14 of the 180, or 11 percent. Seropositivity for hepatitis B virus occurred in 11 people, or 6 percent. Interestingly, none of these people were icteric or had a history of hepatitis that they knew of. Hypogammaglobulinemia was found in 8, or 4 percent, of the group: Lymphadenopathy generalized was found in 4, or 2 percent of the group. And an elevated sedimentation rate of 30 or above was found in 5 patients, or 2 percent.

Other abnormalities which were found in the 180 individuals included one with gastrointestinal candidiasis, two with thyroid disease, one with non-Hodgkin's lymphoma, abnormal liver on echo in several individuals. Thus 25 percent, or one-fourth of the people who were seen in the Persian Gulf Registry had definite documented medical physical abnormalities.

In summary, we at Tuskegee have the opinion that in view of other considerations and the information that has been obtained within the last several weeks by the Czech report we feel that we at Tuskegee should, with cooperation and working with Dr. Roswell out of Birmingham, pursue the consideration that there was chemical and/or biological agents contamination in the theater. We do not speculate on the etiology or the cause of this.

Thank you.

[The prepared statement of Dr. Jackson appears at p. 218.]

Mr. EVANS. Thank you, Doctor.

What led you to deviate from the normal, suggested protocol for a physical examination?

Dr. JACKSON. We had continued the suggested protocol from August until January. In that time, a number of individuals, particularly those in CB 24th in Columbus had stated there were a number of people who were going to private doctors who were ill, and even though we had gotten normal test results from them they were sick.

So, we felt that it was prudent medical, good medical practice simply to expand our testing base to see if we could come up with an organic basis for the illnesses which these veterans were complaining of.

Mr. EVANS. You are reported to have stated that at least 5,000 veterans have possibly been subjected to some type of genetically altered biological toxin. Is that correct?

Dr. JACKSON. I don't think that is exactly correct. I think the statement was that there are approximately 5,000 people who are on the Registry who are ill and having medical problems.

Mr. EVANS. How would you define Persian Gulf syndrome? How is it defined? Is it acute or chronic? And is it disabling?

Dr. JACKSON. Well, I don't think you are going to find it in the medical textbooks. Loosely, individuals (1) who had been in the Persian Gulf; (2) had problems, the symptoms of which have been described before, who could not—rather did not have an explanation which could come under definite diagnosis.

I think the two things are put together and we just simply describe it as the Persian Gulf syndrome. We didn't really know why they were having problems, but we knew a lot of the things that they did not have.

Mr. EVANS. How is chemical or biological warfare agents exposure determined, and is this disabling?

Dr. JACKSON. I think there are several parts to the answer to that question. One is it is basically going to be determined by, as mentioned before, if the levels are high enough there will be a body's reaction to that, or using the chemical detectors that the military have provided for the veterans.

Number two, there is some question as to whether or not low levels of chemical exposure have long-term disabilities. This is one of the things that Dr. Roswell is going to be investigating in Birmingham. And, in terms of the biological aspects of low exposure, we don't have a lot of answers on that, and that is one of the things that we are going to be pursuing at Tuskegee, if we can test for biological agents.

We know that tests can be done and we know that tests are available. The question is whether or not we could be able to detect biological agents. And number two, we will have to do some testing and working with individuals on whether or not there are long-term consequences of exposure.

Mr. EVANS. The illnesses that you have found to be in 26 percent of the group are abnormal illnesses, should they enable veterans to be compensated as service-connected? Can you show that?

Dr. JACKSON. One of the problems that we have is you cannot absolutely prove that these individuals were normal under these tests prior to being deployed to the Gulf. In other words, these tests are not normal tests which would be obtained in a routine physical examination.

We must, I think, assume though that individuals who are in the reserve, who meet the physical test requirements periodically, who are deployed to a combat area, I think we must assume that they are basically in good health.

And finally, the association of symptoms with the abnormal test results that we find suggests that these individuals did not have these problems prior to deployment to the Gulf.

Mr. EVANS. When you say we in terms of Tuskegee, you mean other colleagues of yours that are interested in pursuing biological warfare——

Dr. JACKSON. Yes. We have a team of people that we get together periodically to discuss what tests need to be done next, exchange thoughts, et cetera, and one of these teams is the Research Committee which has helped other physicians there. So it is not per se a really organized body, but it is a group of people that have been kept abreast of what the thinking is and the results that we have given you.

Mr. EVANS. Who heads that specific task force?

Dr. JACKSON. Well, I guess technically the Chief of Staff is over the group of individuals, and we keep him abreast of the general overall trends in test results, et cetera. The day-to-day activity I guess is the responsibility of the environmental physician at the hospital.

Mr. EVANS. Let me yield to the gentleman from Alabama.

Mr. BROWDER. Thank you, Mr. Chairman.

It is ironic—if you will allow me just a minute. Some people have asked me why I became interested in this issue and why I went to the Czech Republic to examine the Czech reports when there were rumors about it. Besides having veterans of the Gulf War who had these mystery ailments, I also have in the Third Congressional District of Alabama the Nuclear, Biological and Chemical Center, the U.S. Army Chemical School, which is the home of chemical and biological defense training and the only live agent training facility in the free world. I also have in the Third Congressional District of Alabama one of the eight continental U.S. stockpile sites where chemical weapons have been stored for the last half century and that we have to dispose of for the Chemical Weapons Convention.

And you guessed it, Dr. Jackson and Tuskegee VA Center are in the Third Congressional District of Alabama. So we have, I have an intense interest in this, and I would like to ask Dr. Jackson a few questions, leading questions, because I think that they are pertinent to what he has testified to before your committee before and today.

And, Dr. Jackson, I will ask you to answer these as briefly as possible, if you will, so that we can—I think it will lead us in a productive direction, but I would like to leave room for other people to ask questions.

You have talked—I have pursued and followed your statements all along, and I noticed one thing about your statements. Despite what the headlines said, you have always talked about chemical or biological exposure, possible symptoms, and that interested me, because in the beginning we were just talking about possible chemical exposure.

Can you differentiate, and just briefly tell us, how do you differentiate between whether you think somebody, perhaps—nobody is asking you to say that something caused something, but you can identify symptoms that are not incompatible with chemical exposure or biological exposure. How do you differentiate between whether something is suspected, somebody is suspected of having chemical exposure versus somebody who has had biological exposure? Is that possible?

Dr. JACKSON. Symptomwise the answer is probably no. It would depend on the levels of the chemicals and the levels of the biological exposure.

Mr. BROWDER. But if you—you can devise a grid or a chart, say, for high exposure or low exposure with pertinent symptoms? If somebody were exposed to chemicals, that would be different from somebody who were exposed to biological?

Dr. JACKSON. That is possible. It is stretching the point.

Mr. BROWDER. Okay. Then how do you say that you expect—that you would like to examine biological as opposed or in addition to chemical?

Dr. JACKSON. There are a number of considerations. One is the recurrence of the symptoms in the veterans. Ordinarily, if you have a one point or zero point in time exposure to a low chemical agent, as an example, low level of chemical agent, one would expect

maybe no symptoms or one would expect symptoms over a short period of time and then a resolution.

If one has moderate or high level exposures of a chemical agent, one could expect recurrent symptoms, but one would expect for the individual at the scene to have had a physiological reaction, which was described by the members of the prior panel.

So, basically, you can feel confidence in saying that there were not moderate or high levels of chemicals in the theater or the soldiers would have gotten sick right then.

The interesting thing about a biological agent is that you can have low levels of biological agents, either one point exposure or exposure over a period of time, still having levels which are not detectable through the detection methods which from my understanding are used by the DOD but that the accumulation of the effects of these agents are cumulative and they could cause long-standing and permanent problems.

Mr. BROWDER. Thank you. Can you differentiate between biological weapons, the symptoms that you are talking about, biological weapons and endemic diseases or environmental factors such as the oil fires?

Dr. JACKSON. Endemic diseases, I think the answer is yes. In general medical practice we have a lot of tests which can isolate various kinds of bacteria, typhoid, et cetera, cholera, which do give similar problems, but you would expect to have positive test results showing these things. We have done basically all these different tests and we have found no evidence that in this group of 180 individuals that they are suffering from endemic diseases.

In reference to effects of oil well fires and/or multiple chemical sensitivities from other elements, there are some tests which can be performed, but we cannot say that we have been concentrating in that area.

Mr. BROWDER. And, Mr. Chairman, just very quickly, do you think that this could have happened because of the vaccinations that our soldiers received?

Dr. JACKSON. No, I do not.

Mr. BROWDER. And finally, do you think that the symptoms that you have observed, that you have talked about, that those are markedly significantly different from what you would expect to find in the general population?

Dr. JACKSON. Yes.

Mr. BROWDER. Thank you.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you.

Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Dr. Jackson, I want to personally thank you for all the work that you have done for the 24th Naval Construction Battalion, Attachment 1624, the Seabees out of Columbus, GA. They have felt like all along it has been coming to Tuskegee that you were and are an ally for them, and that oftentimes you were the only one that was really giving them the attention that they so deserve.

You conducted testing on members of the 24th CB unit from Columbus and I believe you also sent a letter on July 17, 1993, to the commander discussing the severity of problems on that unit, and

I also understand that one of the Seabees was diagnosed with lymphoma cancer, four more have been tentatively diagnosed with early stages of lymphoma cancer, and 11 believe that they have tested positive for HTLV–1 and 2 which can cause lymphoma cancer but have not been shown their diagnosis.

How many members of that unit did you test for the HTLV–1 and 2 virus and how many of the unit tested positive?

Dr. JACKSON. You must understand that we did not have immediate financial resources to go into a whole unit and test the whole unit. So, what we decided to do was in view of the fact that we knew that certain members of the CB24 were very ill, and one of which had non-Hodgkin's lymphoma, we felt that testing the sickest members of that group would be appropriate to tell us if we were going in the right direction or not.

We tested—well, approximately 50 to 60 individuals were in that detachment which went to the Gulf, and we tested what we felt were the sickest ones, including the gentleman with non-Hodgkin's lymphoma. So, we tested approximately 12 or 15 individuals out of that unit and none of them tested positive for the HTLV–1 or 2 virus.

Mr. COLLINS. Did you not tell Michael Moore, Roy Morrow or Roy Butler that they tested positive?

Dr. JACKSON. No. What I think is indicated at this point is to just briefly discuss the virus, the fact that the virus is a natural virus, the fact that it is found in approximately 1 out of 5,000, 1 out of 6,000 naturally and is not associated—every time you find the virus there is no association of illness. So, the virus can be found naturally.

The question that we had was does a high number of that group have the virus or parts of the virus? Now, in order to make the diagnosis that these individuals have the virus what we must do is—the test is broken down into a sequence of different tests because the virus is broken down, in terms of testing, into different portions. In order for the diagnosis to be made that a person has the virus, one should test positive in four of these different test areas for the virus, and we found that no individual in that group that we tested had the entire virus.

Now, the particular individuals that you are discussing they did test positive for part of the virus, and the fact that those individuals tested positive for part of the virus was not statistically significant in terms of being able to say. Well, if the whole group tested positive for the same part of the virus, we would have been suspicious, but the whole group did not test positive for the same part of the virus, which is acceptable statistical normality.

Mr. COLLINS. Okay. I understand that we are going to retest these same individuals.

Dr. JACKSON. That is a possibility, but at this point we are not really seriously considering HTLV–1 and 2 as being the etiology of their problem.

Mr. COLLINS. The Seabees tell me that you told them that they had a live virus, as they so called it, and told them that they could not donate blood for life and that they must practice safe sex and take other precautions because the disease is communicable. Is their illness communicable?

Dr. JACKSON. I think there is a little misunderstanding here. I think that what we were trying to communicate with them was that (1) we don't know what their problem is, we don't know if they have an illness which can be communicated to their spouses, and we did have individuals of that unit whose wives had come down with medical problems which were not diagnosable by their physicians, and so we were suspicious there might be some communicable problem in this.

It was just simply good medical practice to caution them about their options, the possibilities. But I don't think that we ever said you definitely have the virus and you definitely are contagious because of the virus. We have never known anybody had the virus.

Mr. COLLINS. Can you elaborate on the letter you gave to Larry Kaye about his diagnosis as being chemical-biological warfare exposure?

Dr. JACKSON. Yes. That was a clinical diagnosis based upon a number of considerations. One, Mr. Kay and other members of his unit had gone through a good, extensive battery of tests, all of which had shown nothing. Number two, I was in personal contact with doctors at Bethesda, and since he is a member of one of the 12 detachments of the CB24, I had been given the names of 70 other individuals in CB24 scattered throughout the Southeast who were ill, some of which had gone to Bethesda, some of which had the same "we don't know what is wrong with them" diagnosis.

So, in view of all of that, it was a safe clinical opinion that, because we had cut down all the other trees, they were exposed to chemical and biological agents.

Mr. COLLINS. Very good. Thank you, Dr. Jackson. And again, I want to thank you for the service you render to those veterans. They have a lot of confidence in you and hopefully that you will be able to continue servicing them in conjunction with the Birmingham pilot program.

Thank you, Mr. Chairman.

Mr. EVANS. The gentleman from Massachusetts.

Mr. KENNEDY. Thank you, Mr. Chairman.

Dr. Jackson, I just want to follow up a little bit on the answers you just provided to Mr. Collins. I am still a little bit confused. I think there was a situation where, as I understood the facts that you provided us, there are 50 or 60 guys that had some sense that they were sick, is that correct? Out of this entire battalion? Or is that 50 or 60 people in general?

Dr. JACKSON. Let me help you with that. There are 12 different cities that have branches of this 24th CB battalion. Columbus is only one of those cities. Approximately 800 members comprise the whole battalion.

Now, 15 percent of that whole battalion is sick. The 50 individuals of the Columbus area are only members of one detachment, and maybe 25 or 50 percent in that group is ill also.

Mr. KENNEDY. Okay. So you got—out of 800 guys, you got a—soldiers—120 of them are sick about, is that correct?

Dr. JACKSON. Yes.

Mr. KENNEDY. All right.

Dr. JACKSON. Now, this is information I have gotten through communication with the regimental headquarters in Atlanta on the

other members of the CB24 and also talking to individuals of the CB24 in other places—Greenville, Asheville, Atlanta, et cetera.

Mr. KENNEDY. We appreciate that, Doctor.

Now, out of the 120 fellows that got, or folks that got sick, do most of them have similar symptoms that you are familiar with?

Dr. JACKSON. Most of them have symptoms under one of those 7 or 8 categories that we talked about—diarrhea, fatigue, shortness of breath, lymph node swelling. Yes.

Mr. KENNEDY. Are those illnesses that they are suffering from, in your professional opinion, caused by some—in all probability by some similar event?

Dr. JACKSON. Yes.

Mr. KENNEDY. Do you think that event occurred at one time?

Dr. JACKSON. Let me——

Mr. KENNEDY. Or perhaps, did the same event occur over a number of exposures?

Dr. JACKSON. That is what I was going to elaborate on. The veterans of that particular unit specifically talk about—excuse me—January 20th, 1991. In that particular incident they specifically noted physiological body symptoms, the itching in the mouth, the skin, et cetera, et cetera, but it is very possible that this is an accumulation of a number of——

Mr. KENNEDY. I understand. I understand, Doctor. I only have a couple of minutes left, so please let me just ask you some quicker questions. Okay?

Now, do you have any information, did you look into in any way or ask the Department of Defense about the possibility of any kind of event, a violent event that took place on January 20th, 1991.

Dr. JACKSON. No, I didn't.

Mr. KENNEDY. Don't you think that would be a logical question to ask? Did you ask any of the men?

Dr. JACKSON. Yes.

Mr. KENNEDY. And what was their response?

Dr. JACKSON. They said yes, and they have testified before committees stating that this——

Mr. KENNEDY. I understand. Yes, I understand.

Dr. JACKSON. See, I didn't have a reason to directly approach the DOD because they were saying that nothing happened and it had in terms of chemical and biological agent exposure.

Mr. KENNEDY. Okay. Now, if 120 of these fellows have one of these or several of these eight symptoms, they all indicate a particular day when they feel that these symptoms came on, they all happened to be in a strange country that was under military attack, would it be your professional opinion that given the answer you just gave us a few minutes ago that this was not an issue that necessarily was pertaining to a chemical agent—you did indicate that this would be a possibility or a probability of some kind of biological agent?

Dr. JACKSON. The problems they are having are also consistent with a biological agent which we know has been used in that theater before.

Mr. KENNEDY. When you say "which we know has been used in that theater before," can you explain that a little bit, please?

Dr. JACKSON. Yes. Particularly, in 1984 in the Iran-Iraq war there was an attack on Marginoon Island where the Iraqis attacked the Iranians and they used, and this was documented by the United Nations, they used a combination of chemical and biological agents in the same attack.

Mr. KENNEDY. Doctor, has there been any attempt by anyone to attempt in anyway to pressure you to come up with anything other than your own personal best analysis and decisions as to what might have taken place?

Dr. JACKSON. I just want to make a slight correction. This is not just my opinion. We have a group of people at Tuskegee and over the last 8 months we have progressed from thinking that this was an endemic disease problem or hepatitis problem or HTLV problem to a chemical and biological agents problem.

Mr. KENNEDY. That is your professional opinion and the group that you work with's professional opinion?

Dr. JACKSON. Yes.

Mr. KENNEDY. Did anybody in any way try to denigrate that decision, try to in any way create any pressure on you to change your opinion from your professional opinion?

Dr. JACKSON. No. Basically, no one outside of the VA, this group that I am talking about, knew that we were progressing towards that opinion, so no one could really influence it.

Mr. KENNEDY. Mr. Chairman, if I might just ask one additional question, or I could ask you the question.

I had read in the newspaper of Dr. Jackson's work, and there was a great to-do about that work maybe a week and a half or 10 days ago—2 weeks ago.

Then I read in the newspaper that you had retracted your position and that you no longer were maintaining that this was—that these fellows got sick as a result of potential——

Mr. EVANS. Will the gentleman yield? I think that was in one specific diagnosis, not a general across-the-board diagnosis.

Mr. KENNEDY. Okay. That is exactly what happened?

Dr. JACKSON. I think what is confusing the issue is that the letter was written and it mentioned the chemical and biological agents. I think it should be considered a fact that this was not the official opinion of the VA and that I think accounts for the differences.

Mr. KENNEDY. When you say it is not the official opinion of the VA, it happens to be the official position of the group of doctors that was responsible for looking into this battalion's sicknesses. Is that correct? And how many doctors?

Dr. JACKSON. Two physicians, one nurse, and then we have two other people we talk to and discuss things, Chief of Lab, et cetera.

Mr. KENNEDY. Okay. Thank you very much, Mr. Chairman.

Thank you, Dr. Jackson.

Dr. Shayevitz, if I could just say there are a lot of veterans up in new England that very much appreciate the efforts that you have made on their behalf. I know that you have come under personal attack for many of the kindnesses and the professionalism that you have shown, and we just want to let you know that we appreciate your willingness to stand up for veterans that were ex-

posed to multiple chemicals in their service to the Gulf. You have done a great job and we thank you very much for your efforts.

Thank you, Mr. Chairman.

Mr. EVANS. Let me echo that. I have a few questions on the next round that I want to ask you, so please bear with us.

The gentleman from Alabama.

Mr. BACHUS. Thank you.

Dr. Jackson, the unit you are talking about that is the sickest is a Seabee unit?

Dr. JACKSON. Yes.

Mr. BACHUS. How many are sick?

Dr. JACKSON. I want to state that of that 180 there are only 15–20 individuals.

Mr. BACHUS. Are you saying 15 or 20 of the unit?

Dr. JACKSON. Yes. But there are 80 other individuals from other units that are just as sick or even sicker than they are.

Mr. BACHUS. Okay. Let's just discuss the Seabee unit. You have seen 20 people from the Seabee unit?

Dr. JACKSON. Between 15 and 20, yes.

Mr. BACHUS. Fifteen and twenty? Do any of them have cancer?

Dr. JACKSON. Only one.

Mr. BACHUS. One?

Dr. JACKSON. That we know of, yes.

Mr. BACHUS. How about their lymph glands?

Dr. JACKSON. Yes, four or five of those individuals besides the one with the cancer have lymphs swollen.

Mr. BACHUS. What does that indicate?

Dr. JACKSON. It suggests that their immune system is attempting to fight something or other. They have a reaction which is affecting their immune system.

Mr. BACHUS. So, there are approximately as many as a third of them who have some unidentified infection?

Dr. JACKSON. Are you just talking about the lymphatic swelling?

Mr. BACHUS. Yes.

Dr. JACKSON. Well, 5 out of 50. We use the number 50, so that is 10 percent.

Mr. BACHUS. All right. Is that within the Seabee unit?

Dr. JACKSON. Within that detachment. Of those 50 individuals that went to the Gulf, let's say 5 of them have lymphatic swelling and one of which has cancer.

Mr. BACHUS. If you have an exposure to a biological agent, would it cause an elevation in your lymph? Would your lymph system respond in that way?

Dr. JACKSON. It depends on the agent, and the agent that we are looking at primarily, yes, it targets the lymphatic system.

Mr. BACHUS. What is that agent?

Dr. JACKSON. They are called mycotoxins.

Mr. BACHUS. Mycotoxins?

Dr. JACKSON. Which are the same agents used in the attack in 1984.

Mr. BACHUS. By Saddam Hussein?

Dr. JACKSON. Yes.

Mr. BACHUS. Was that in a binary—was that used in conjunction with chemical warfare too?

Dr. JACKSON. Yes. This particular attack was the first documented attack by the United Nations of the combined use of a chemical and a biological agent in the same episode.

Mr. BACHUS. And that technology has been around for years and years, hasn't it?

Dr. JACKSON. At least a decade.

Mr. BACHUS. All right. Have you heard reports from the veterans that their wives and children are also suffering?

Dr. JACKSON. Yes, I have. We have gotten calls from all across the country of spouses who are having problems.

Mr. BACHUS. Is that consistent with a biological agent?

Dr. JACKSON. Yes, it is. It could depend upon what type of biological agent, but yes.

Mr. BACHUS. So, a soldier could be exposed to a biological agent in the Gulf. He could come home and infect his family members?

Dr. JACKSON. Yes.

Mr. BACHUS. Would we call that contagious? Would that be contagious? Is that the right word for it?

Dr. JACKSON. That is an acceptable word.

Mr. BACHUS. So the condition could be contagious?

Dr. JACKSON. Yes, which explains why Mr. Collins was making his comments and why we say, well, we don't know what we are dealing with, so you might want to take precautions.

Mr. BACHUS. Have you been in communication with the CDC?

Dr. JACKSON. Yes, we have.

Mr. BACHUS. What has been their response?

Dr. JACKSON. Well, we have been in communication with several elements of CDC, one of which was we were considering a problem with the vaccination process and we communicated with the vaccine area of CDC, and the other is in relation to a communicable disease, which we are discussing now, and so we are going to go working with them on an epidemiological study.

Mr. BACHUS. Are you satisfied with their response to date?

Dr. JACKSON. Yes.

Mr. BACHUS. I have no further questions.

Mr. EVANS. Does the gentleman from Alabama have more questions?

Mr. BROWDER. Dr. Jackson, just to draw to a close on my questions about your work, I don't want to put words in your mouth, but you and I have had some discussions. For the next month or couple of months, you are going to be studying these veterans. You and Tuskegee and Birmingham are going to be conducting a pilot study.

Dr. JACKSON. Yes.

Mr. BROWDER. Would you recommend that as part of that study that these veterans be also included in the protocol, that they would be checked for cancer?

Dr. JACKSON. I don't have any objections to it, but Dr. Roswell is over the pilot study, so that would need to be discussed with him as to how he wants to approach the situation.

Mr. BROWDER. Would you recommend that part of the protocol be that they, their spouses be checked or that they be asked about their spouses or family members as they are examined?

Dr. JACKSON. We do that automatically.

Mr. BROWDER. You do.

Dr. JACKSON. That is already part of our questioning.

Mr. BROWDER. Okay. And would you recommend that the CDC become more involved in this effort?

Dr. JACKSON. Well, we are going to be approaching them even more, so we expect them to be involved, because the spouses aren't eligible under the VA, so looking into their health problems will have to be under some organization, and I can't think of any other except the CDC.

Mr. BROWDER. You are participating in the pilot study. Are you personally professionally satisfied with the work that the pilot study, the way that it is designed now and the way that it is going to be working?

Dr. JACKSON. Yes, but it's just starting. But I think Dr. Roswell is an incredible and a fantastic individual and I think he is going to go in the right direction.

Mr. BROWDER. Do you think that we will be able to get an answer when this pilot study is completed, get an answer about whether these people have symptoms that are compatible with chemical exposure and/or biological exposure?

Dr. JACKSON. We definitely hope to have some statistical information in about 90 days.

Mr. BROWDER. Ninety days.

Dr. JACKSON. We, depending upon the problems we run into, we may or may not have answers about chemical or biological exposure. But we are hoping to, with verification and getting control groups and comparing blood samples and things like that, we are hoping to have some answers in about 6 months.

Mr. BROWDER. Thank you very much.

Thank you, Mr. Chairman.

Mr. EVANS. All right, doctor, I think we will have some additional written questions to submit to you and your answers to those questions will be made part of this record.

Dr. Shayevitz, I understand the VA agrees with AMA's Council on Scientific Affairs which concluded, number one, that there are no well-controlled studies establishing a clear mechanism or cause for MCS; and two, that there are no well-controlled studies providing confirmation of the efficacy of the diagnostic and therapeutic modalities relied on by those who practice clinical ecology.

Do you agree or disagree with the VA's agreement with the AMA?

Dr. SHAYEVITZ. If the VA in fact did say that I disagree with them.

Mr. EVANS. Are there then any well-controlled studies which establish a clear mechanism or cause for MCS?

Dr. SHAYEVITZ. There has been a lot of research done. There was an entire symposium by the National Research Council on MCS. Controlled studies have been difficult to do, it is true, but what I meant was if the VA in fact said there is no such entity as MCS, and I have not known them to say that, it is to that which I disagree.

I want to point out what I pointed out before. That brilliant researcher at M.I.T., Dr. Nicholas Ashford, who somebody was trying to remember his name here, and that places such as Mass General,

Yale and other prestigious universities, all recognize this syndrome diagnosis and treat it.

Mr. EVANS. All right.

Dr. SHAYEVITZ. You know there are many diseases which we treat that we don't know the cause of. In fact, perhaps most of the diseases we treat we don't know exactly the cause of them.

Mr. EVANS. Let me take it one step forward from that. In your personal opinion, if you make a diagnosis that a veteran has MCS, should the Veterans Benefit Administration accept this diagnosis when adjudicating the veteran's claim for service-connected disability compensation?

Dr. SHAYEVITZ. Yes. And, you know, multiple chemical sensitivity is recognized by the Social Security administration at this time. That is the reason they get Social Security disability.

Mr. EVANS. Family members of some Gulf veterans have also reported developing some of the symptoms experienced by these veterans. Is MCS communicable?

Dr. SHAYEVITZ. No, it isn't. But I would like to remind you that up to 15 percent of the population of the United States according to the National Research Council may have multiple chemical sensitivity syndrome, so it is possible that families of veterans may have this disorder also.

And one useful theoretical model is that we are all individuals and we kind of had to be tolerable, biological, psychological and chemical, and when that is exceeded MCS can result. And I can tell you that the spouses of these veterans are on overload from the stress of their husbands being so ill.

Mr. EVANS. Doctor, thank you.

The gentleman from Alabama.

Mr. BACHUS. Doctor, are you familiar with Dr. Hyman in New Orleans?

Dr. SHAYEVITZ. I only know what I read in the paper. I did try to call. I called his office but I wasn't able to speak to him.

Mr. BACHUS. Have you read about his regimen, what he is doing by putting these people in the hospital, isolating them from offending chemicals and treating them with antibiotics?

Dr. SHAYEVITZ. Well, only in the newspapers.

Mr. BACHUS. All right. So, you are not familiar with what his treatment routine has been?

Dr. SHAYEVITZ. No, not intimately.

Mr. BACHUS. From a layman's standpoint, I look at what you are doing and you are basically isolating these people away from allergens, is that right?

Dr. SHAYEVITZ. I am recommending that we do that.

Mr. BACHUS. You are recommending, yes.

Dr. SHAYEVITZ. I have no way to do that at this time. From not only allergens, but all chemical incitants as well as allergens.

Mr. BACHUS. Have they been desensitized? That is what you recommend doing, is that right?

Dr. SHAYEVITZ. I am recommending something which would cause what we call deadaptation. I will use an easier word to understand—detoxification, being away in a chemically clean world, with very clean atmosphere, clean water, organic foods that are rotated in another complete program.

Mr. BACHUS. Did you recommend any antibiotics or medication with this treatment?

Dr. SHAYEVITZ. I recommend antibiotics if there is an infection.

Mr. BACHUS. All right. Dr. Hyman has done basically what you are recommending. He has isolated these individuals in a sterile environment for some, I think, 2 weeks or 3 weeks and treated them.

Dr. SHAYEVITZ. And that will cause deadaptation. If you do that people will get better.

Mr. BACHUS. Yes. And I will tell you that he has been very successful, and you may have heard. And it sort of strikes me as very similar to your proposal, although there are things that you propose that he doesn't. But it is the same approach.

Let me ask you about this. When we have had veterans come before us they have also—I saw a list of your symptoms—talked about bronchitis and loss of pulmonary function. That is not listed as one of yours, but have you found that it could be symptomatic?

Dr. SHAYEVITZ. Well, that is very common, though. Respiratory symptoms are very common.

There are so many symptoms, when I took the list out of the book I took a simplified, you know, list.

Mr. BACHUS. Right.

Dr. SHAYEVITZ. Nasal symptoms. Respiratory symptoms are extremely common.

Mr. BACHUS. With this condition?

Dr. SHAYEVITZ. Oh, yes.

Mr. BACHUS. Because they are having an allergenic reaction or allergic reaction?

Dr. SHAYEVITZ. Right. And because there is a lot of nasal irritation from sensitized—the nasal lining cells are very sensitized and irritated in a lot of cases.

Mr. BACHUS. All right.

Dr. SHAYEVITZ. You know, I would like to just mention one rather elegant theory which ties this all together, and that is that the nerves in the nose, the nerves of smell, go directly to the brain without any blood brain barrier. And to what part of the brain? The limbic system. And what does the limbic system govern? The immune system, the reproductive system, eating disorders, emotional disorders, and that once the brain becomes sensitized or what we also call kindled, that means that we have started with this agent out here. Now, it spreads, so that tiny exposures of very common chemicals send all these amplified neuronal responses to the hypothalamus and limbic system, and to me this ties the whole theory together.

And these patients and some of the tests that I recommend, they have depletion of natural killer cells and these are the patients who come down with the cancers. They have problems with their immune system. They have problems with reproductive systems and we are hearing today about a variety of problems in the reproductive field.

So, I think this is a very important neurobiological theory which has been tested, well tested in animals, by the way, and I feel that it ties this whole syndrome together.

Mr. BACHUS. All right. Thank you very much.

Mr. EVANS. Doctor, thank you. What is the current status of your proposal at Northampton?

Dr. SHAYEVITZ. The current status is that it is now funded.

Mr. EVANS. All right, Doctor, thank you, and Dr. Jackson. We will now stand in recess for about 10 minutes.

[Recess.]

Mr. EVANS. If everyone would be seated we would appreciate it.

Our next witness is Maj. Gen. Ronald Blanck, Commanding General, Walter Reed Army Medical Center.

General Blanck, the committee understands you rewrote your statement last night?

General BLANCK. Yes, sir.

Mr. EVANS. We look forward to receiving your comments this morning and invite you to proceed whenever you are ready.

STATEMENT OF MAJ. GEN. RONALD R. BLANCK, COMMANDING GENERAL, WALTER REED ARMY MEDICAL CENTER

General BLANCK. Thank you. As always, I appreciate the opportunity to give you some update on the medical issues regarding the illness now characterized as the Persian Gulf syndrome.

DOD has worked closely with the Veterans' Administration since we became aware of the syndrome shortly after the end of the war, and, in fact, in mid–1992 sent out messages to all of the commands asking that this illness be reported and worked with the VA on developing a standardized evaluation physical examination mechanism.

Our main concern at the time was to identify those with this illness without all of the problems with having profiles being separated involuntarily from the military and so forth, and to provide medical care either in the military facilities or in the Veterans' Administration hospital. Though there were many, many problems that were faced in that regard, I think we are able to say that by and large we are doing that today as well as we can, because we still have significant problems in understanding exactly what the illness is and, in fact, even in defining it.

DOD at this point has a group of civilian physicians working to come up with a case definition, I described that to you at my last testimony, so that we can do the epidemiology studies that some groups have recommended and that I fully support, and once we have that completed, hopefully that will be this year, we will be able to proceed with setting up the models in those studies.

We also continue to look for causes, and with my cover memo is an information paper that tells you the status of our studies into the oil fire smoke, depleted uranium, leishmaniasis, and so forth.

In general, our tack has been, after seeing that folks got the best care we could give them given that—it is very frustrating since we can't give good answers because we don't know them—is to look at specific causes, and in the absence of those specific causes to look at areas such as chronic fatigue syndrome and multiple chemical sensitivity. You have heard testimony about that and I think you know where we are in addressing that.

There is a subgroup within those complaining of the Persian Gulf syndrome that seem to have a very specific single exposure to something that then has caused this illness, or at least the illness

has followed that exposure, and the sentinel group of that is the 24th Construction Battalion—the Seabees—in Columbus, GA.

The Navy along with the Veterans' Administration is doing a full-scale epidemiologic evaluation of that. They will visit the Seabee unit, I believe, the 11th and 12th of December, interview all of them, and the Navy is also sending a team to Al Jubail to look at what kind of chemicals this unit might have been exposed to that will help us in, I think, trying to evaluate everyone else.

I would particularly thank the committee for their help in providing funding for ongoing research, particularly in the multiple chemical sensitivity area, and although I believe the VA as of August of 1993 has been designated the lead agent for research and has moved out with lots of initiatives, we will continue to work on following those that have been exposed to depleted uranium, oil fire smoke and all of that kind of thing that we have already done.

With that, I would ask if there are any questions?

[The prepared statement of General Blanck, with attachment, appears at p. 200.]

Mr. EVANS. Thank you, general.

The gentleman from Alabama.

Mr. BROWDER. Thank you, Mr. Chairman.

General Blanck, I have a couple of questions pursuing a line of inquiry that I have been following about the possible exposure of our military forces to low level agents.

I said this morning that I am not impressed with the Department of Defense's responsiveness on this issue. I guess the main thing that frustrates me is that the Department of Defense is issuing very circumspect statements in dismissing the possibility that these veterans' problems are related, might be related, to exposures.

As a matter of fact, I have got the Department of Defense report that says, "Given the limited locale of the incidents, the very low level of agent reported and the absence of other valid detections there is no plausible connection between the Czech report and the symptoms being experienced by some Gulf War veterans."

Throughout the Defense Department's statements wiggle words are placed in at certain places but the message is always the same: We see no reason to think that there is any connection between possible, between these problems and any possible exposure that may have occurred.

That concerns me because we have got sick and dying veterans who do have problems. I am not saying as a truism that these veterans are sick and dying because of this or that. What I am saying is that the Department of Defense has been rather cruel in making these, and irresponsible in making these statements, and I think that we have got to pursue them and identify the circumspection of the Defense Department's statements.

For example, in the Department of Defense release about dismissing the exposure, and even in your statement, "Based on the levels reported and our knowledge of effects of chemical warfare agents, long-term health consequences would not be expected."

I looked at the assessment, the health assessment and the technical assessment, and I keep seeing examples where the assess-

ment says "known health effects of GB and HD." That word known is very important and very deceptive there.

Now, I know you are trying to be very careful in your statements, but it leads to the wrong—it sends the wrong message on nerve agents. Low dose, you say "No symptoms at all." But on long-term effects you say, "Low dose, no known long-term health effects in exposed individuals." On mustard agent, long-term effects, low dosage, "there are no known long-term effects for short term, low dose."

Those are true statements but they communicate, I think, a message that we cannot accept. The Defense Department is emphasizing "no known," and that is being used to dismiss something that we may not know about.

As a matter of fact, we say no known long-term of low dosage, it is hiding the fact that we really don't know much. That is not saying that we've got extensive scientific research about low dose and all of it is that there is no known effect.

The fact is—and if you disagree with me, disagree with me now—we do not have extensive research, scientific research on low dose long-term effect of these agents.

General BLANCK. If I may, sir, you are correct. We do not have research on low-level exposure that causes no symptoms. We have a considerable body of research from studies done from the mid-fifties through the mid-seventies on low level exposure that was enough to cause symptoms and that was reported by the National Academy of Sciences. However, even they qualify their conclusions.

And so, in summary, I would agree with you that we must keep an open mind, number one. Number two, the intent was by no means to dismiss either the illnesses or the potential causes, but simply to put it in perspective, because we need to be very careful that we focus on getting at the truth, whatever the truth is, and that is the real causes, and I think you and I share exactly that perspective.

Mr. BROWDER. General—and Mr. Chairman, if I could pursue this because I think this is very, very important?

Mr. EVANS. I would yield my time to the gentleman.

Mr. BROWDER. We have to be very careful because I think this is being misconstrued. Let me read from the—you cited, and Dr. Deutsch cited, some studies, some literature that he had that demonstrated this no known effect. I have some of that research here that was cited in that press conference, and I would like to read two paragraphs.

"The panel therefore is unable to rule out the possibility that some anti-CHE agents produce long-term adverse health effects in some individuals. Exposures to low doses of OP compounds"—and those are the things we are talking about—"have been reported but not confirmed to produce subtle changes in EEG, sleep pattern and behavior that persist for at least a year."

And then "No firm evidence has been seen that any of the anticholinergic—you will have to correct my pronunciation of these—"test compounds surveyed produce long range adverse human health effects in the doses used at Edgewood Arsenal. More intensive study is required to confirm this conclusion."

General BLANCK. Yes, sir.

Mr. BROWDER. I would like to read an opening paragraph from a paper that was given to us at the pilot study in Birmingham this past week, "Possible Long-Term Health Consequences of Exposure to Nerve Agents."

"Relatively little is known about the long-term health consequences of exposure to nerve agents because of their limited use in war time and the difficulties in identifying and following individuals who may have been exposed."

I would like to read to you from—if I can find it—a 1992 textbook, Chemical Warfare Agents, which opens Chapter 5, "Behavioral Effects of Low Dose Nerve Agents": "Most biological research on chemical warfare agents has been concerned with prophylactic and treatment strategies for high dose, potentially lethal exposures. Consequently, there is a sparsity of data on behavioral effects of low level exposures."

As a matter of fact, that textbook notes, "Not only does high exposure to nerve gas lead to unconsciousness, convulsions, breathing problems, and death," but the same book also notes that "lower exposures lead to vision problems, tightness in the chest, forgetfulness, irritability, poor judgment, lack of comprehension, tenseness, depression, insomnia, and nightmares."

As a matter of fact, if you go back there is an Army field manual, back during the Cold War, and I don't know the date on it—an Army field manual dating back to the Cold War entitled Chemical, Biological and Radiological Operations that states that nerve gas, how it kills, and then the manual states this about GB or Sarin, the nerve gas detected twice by Czech troops:

"Any exposure to GB lowers the body cholinesterase level. Repeated exposures to even low dosages over a period of days or weeks gradually lower the cholinesterase level until the individual becomes a casualty."

General Blanck, I really think that these statements by the Department of Defense with the few wiggle words like "known" or "as of now" are being used to footnote the possibility with the bulk of the material coming out of the Defense Department, besides saying we are going to study this and try to find out, is saying there is no reason to believe that any of these problems are caused by the possibility of exposure to these agents.

And I would—we are going to pursue this on the Armed Services Committee about why the Defense Department continues to do this. But I would really encourage you to be more evenhanded from now on in talking about the possibilities, that we don't really know a lot about what we are trying to figure out here now.

Thank you very much.

General BLANCK. Thank you, sir, and I assure you that medically I have, we all have an open mind and will continue to pursue this. Thank you.

Mr. BROWDER. Thank you, Mr. Chairman.

Mr. EVANS. Thank you. The gentleman from Massachusetts.

Mr. KENNEDY. Thank you very much, Mr. Chairman.

I want to sort of follow up on the points that Mr. Browder was making. You know, they ought to review the history of your involvement in this issue, General.

But, in your testimony and DOD's health assessment conducted in response to the Czech report you state that "Long-term health consequences would not be expected," and the Pentagon has disconnected any link between chemical and biological agents exposures and the serious illnesses experienced by the Persian Gulf vets.

Now, DOD's immediate denial of these health concerns comes even though DOD Under Secretary Deutsch has admitted extreme limitations in biological agent detection technologies. And in January of this year, GAO reported to the Congress that chemical and biological defense, that the U.S. forces are not adequately equipped to detect all threats. That study indicated that U.S. military—that the U.S. military had extremely limited capabilities to detect biological agents, and at the beginning of the war U.S. troops did not have the capability to detect any Iraqi biological agents.

Now, you are familiar with the fact that some of us have been told that the Czech report might have been—there was at least some possibility that people had ginned the thing up. That maybe people were interested in selling technologies and other kinds of issues that were associated with that.

The impression, again, that somehow these issues are immediately debunked by the Department continues. We had asked for an assessment of FOX vehicles, which in fairness, Secretary Deutsch came back just now indicating that there were no linkages. The letter actually raises a few more questions. But I guess in my own sense—first, there seems to be about three questions that we ought to come to grips with.

First of all, how can DOD write off this exposure? It just doesn't seem to me to make sense.

Second, how does DOD plan to investigate possible biological war time exposures given Dr. Jackson's testimony?

And how do you respond to Dr. Jackson's concerns that biological agents may be the cause of illnesses that vets face with their families?

I don't think our questions or concerns ought to be construed that we are saying that we believe that is the case. But there has been a constant, seeming endless attempt by the Department of Defense to immediately sever any notion of linkage.

Now, I think that there are a few theories as to why that would be happening, but it definitely is happening. And the fact that we have to continue to come back—it takes Glen Browder going over to Czechoslovakia getting the Czech study, demanding that it be made public, the fact that you have Dr. Jackson coming forward as an independent VA physician that is bringing these issues to light. The fact that we have so many individual witnesses that continue to come forward with their cases, I suppose creates a very strong impression that despite the fact that you have been on this case for a considerable period of time that we simply are not getting to the bottom of it. And that is despite your assurances that have gone on now for a year or so, I don't know, maybe 8 months or something, you know, that you realize that your initial reaction to this might have been wrong and that, you know, that you are hell-bent on trying to get to the bottom of it.

I guess we continue to be left with the impression that in fact the Department is doing much more to debunk any possible link-

ages and not to really just have an honest, forthright, complete appraisal of what in fact took place.

So, can you respond to those three specific questions and then maybe the general question as well?

General BLANCK. Yes, sir.

First of all, let me assure you that we do take it seriously and, in fact, are going hell bent in trying to find this out. It isn't easy to do it in the fashion that would both allow us to accurately diagnose and ultimately to treat very rare illnesses. And we do not reject chemical or biologic out of hand. I am sorry if you have that impression.

We simply try to—I believe the Department put it in a perspective that would say it is more or less likely than some of the other kinds of things.

Mr. KENNEDY. Wait a second. I have been to several briefings. I have heard your testimony before. You say there isn't any link. I mean, you know, I don't think that there has been an honest assessment here of whether or not there were linkages. Why do you have to wait for the Czech report?

The fact is that we have been saying, and other Members of the United States House and Senate have been saying this for many, many months. I don't think it is right to suggest that the Department has just been sort of checking this out and you have been trying to be scientifically accurate. That is not what has been going on.

There has been an effort to not investigate it, and any time someone has come forward to basically try to undercut them, that is what has happened.

General BLANCK. I appreciate your comments and respectfully disagree. There has been a serious long-standing effort to get at this. I would submit that we use the terms "chemical" and "biologic" to mean lots of different things. I fully think that this is chemical. I fully think that there may be an aspect of biologic. I don't know if it is warfare agents.

The data that I have been given would suggest that it is not, but I don't reject that out of hand.

Biologic, in fact there were detectors that the British had and gave us some of them. They detect, by particle size, the organisms and, of course, infections, that are results of biologic agents leave markers. They leave markers of elevation of antibodies, nonspecifically, and so forth and so on, altered white counts and all of that kind of thing. That was not seen, and we have looked for them.

As far as chemical agents, I would absolutely agree that the veterans in Desert Shield/Storm were exposed to a multitude of chemical agents. And we have talked about them on a number of occasions from the industrial pollutants stored at Al-Jabayaal to the pesticides that were all over the place. And add to that the possibility, which I would absolutely agree with you, of chemical warfare agent makes it more significant to try to get to the bottom of this; and we are.

Mr. KENNEDY. General, all I am pointing out is that I have seen the Department try to undercut Dr. Hyman. I mean, evidently Dr. Hyman has gotten some money which I was unaware of prior to

a couple of hours ago to investigate his contention that this is a biological agent which was completely laughed off when he testified before this committee.

You know, there was specific attempts to undercut the Czech study which you are very familiar with. There has been a lack of a willingness to check out—any kind of desire to check out the individual cases that have been brought forward. I am not saying that that continues at this time, but that is a recent development.

So, you know, I am not trying to cry over spilled milk. I am trying to point out that it really hasn't been a legitimate effort to date. I hope that is changing. So, let me just—along those lines, let me just ask you one additional question. We have heard a lot of talk this morning about this form that, evidently, servicemen and women were asked to complete with question No. 11.

Are you familiar with the form?

General BLANCK. I am.

Mr. KENNEDY. "Do you have any reason to believe that any members of your unit were exposed to chemical or germ warfare?" Why was that question asked?

General BLANCK. This was a form developed before the conflict where we felt there might be use of chemical or biologic agents, and so that question was included.

Mr. KENNEDY. What were the results of the question?

General BLANCK. To the best of my knowledge, no one acknowledged being exposed to such agents because they were told that they weren't there.

Mr. KENNEDY. Have you asked?

General BLANCK. Have I asked about——

Mr. KENNEDY. Asked what the answers to the form were?

General BLANCK. We have tabulated the forms, as many as we have.

Mr. EVANS. Would the gentleman yield?

Mr. KENNEDY. Yes.

Mr. EVANS. Is this an individual medical record that goes in the individual's file? Or is this document or data for the Department of Defense?

General BLANCK. No. This was for an individual's record. A lot of units collected them and forwarded them.

Mr. KENNEDY. Did you get the results of the question then?

General BLANCK. Yes, sir.

Mr. KENNEDY. Did you?

General BLANCK. Yes.

Mr. KENNEDY. Have you compiled them?

General BLANCK. I can only speak to that one question.

Mr. KENNEDY. And you are saying, out of all of the people that were asked the question, not one single soldier said yes?

General BLANCK. Not in the data that we have. Not that has been reported to me, no.

Mr. KENNEDY. Excuse me if I sound a little skeptical. How many forms have you looked at?

General BLANCK. I have not looked at any. The medical folks have looked at a number of forms.

Mr. KENNEDY. How many?

General BLANCK. Thousands.

Mr. KENNEDY. Are any of them here with you today?

General BLANCK. No. This is——

Mr. KENNEDY. I guess—you know, it just would appear to me that if you have a form out there that asks a specific question and you know you are coming up here, I would think that we would have a little bit better sense.

How about all of these other questions? Like, 2: "Are you receiving treatment at the present time?"

"Do you have fever, fatigue, weight loss, or yellow jaundice?"

"Do you have swelling from lymph nodes, stomach, or other body parts?"

"Do you have any rash or skin infection or sores?"

"Cough or stomach or belly pain?"

"Nausea or diarrhea?"

"Bloody bowel movement?"

"Do you have any urinary problems?"

"Any night problems or trouble sleeping?"

Do you have any breakdown of what the results of those questions were?

General BLANCK. Those were individual physical exam questions. And to those specific things, do I have a breakdown? No. Most of them went into the individual records.

Mr. KENNEDY. Is it hard to pull those records, General?

General BLANCK. Yes, sir.

Mr. EVANS. Will the gentleman yield?

Mr. KENNEDY. Yes.

Mr. EVANS. I must admit that if something was going to hold me up in theatre that I might say "no" to a bunch of questions in order to get home. If someone has said "yes" to any of these questions, would they have been put on hold?

General BLANCK. No.

Mr. EVANS. They are not the population as a whole——

General BLANCK. They are representative. And, in fact, the whole purpose of it was to, one, give a clue for further investigation that might be warranted before they separated and for documentation of problems that might come up later.

Mr. EVANS. Well, individuals who might have said yes, what would have happened to them at that point in time?

General BLANCK. To that question, it would have simply gone in their medical record, because the feeling was that there were no biologic or chemical agents. They might have been questioned on it and probably not much more.

To the specifics, let's say somebody said, I still have bloody diarrhea, that should have triggered a medical response of evaluation.

Mr. KENNEDY. That is going to get, at some point in time, a self-fulfilling prophecy if we say there are no biologic or chemical weapons, which is the point I was driving at a few minutes ago. If you say there were no biologic or chemical weapons, then you have a question on the form—you have no testing equipment to determine whether or not there were, in fact, biological or chemical weapons utilized in the theatre.

General BLANCK. There was a lot of equipment for that.

Mr. KENNEDY. I am going by what the GAO report told the Congress, General. The GAO report told the Congress that U.S. forces

are not adequately equipped—I am quoting from the General Accounting Office—are not adequately equipped to detect all threats and indicated that the U.S. military had extremely limited capability to detect biological agents. And at the beginning of the war U.S. troops did not have the capability to detect any Iraqi biological agents.

Now, you know, again, what we are trying to suggest is if you would come up with a conclusion that there was no chemical or biological agents and then any time there are pieces of evidence that are provided that maybe this conclusion wasn't right, and so what happens is you immediately get into a defensive mode where you are trying to undercut any of that evidence that comes forward. You end up, perhaps, with not a very accurate picture of what took place.

And, hence, the hundreds—you know, when we started down this road, I was told that there was about 24—I remember the number—24 guys that had these sicknesses. Twenty-four. And then the number went up to 240. And then it went up to—you know my office kept getting hundreds of these phone calls.

And so what surprises me is that I would be hearing, as a Member of Congress, about these issues long before the Army itself would have heard about them.

General BLANCK. No, sir. I suspect I heard about them first. All of them. And I don't say even now that I know all of them, because I don't believe I do. I am sure that there are those out there that haven't reported it despite the efforts that we made. So you are right.

And if your issue is, did we and do we take it seriously? Absolutely. Does everybody and did everybody? I don't know. But I do and Health Affairs does and DOD does and the VA does.

Mr. KENNEDY. I know my time has expired, Mr. Chairman. Are you going to ask for more questions? Can I ask one quick follow-up?

Mr. EVANS. I will yield to the gentleman.

Mr. KENNEDY. In a joint letter signed by the Secretary—and I think this question just referred to you as "Secretary Blanck"—but in any event, by yourself and Secretary Aspen, government officials underestimate the scope of the unexplained Persian Gulf illness stating that there are only 250 personnel in the category of, quote, mystery illness.

Obviously that doesn't mesh with the hundreds of reports that we have heard. Do you remember that notion of 250 personnel?

General BLANCK. Yes. That we were aware of. That is correct, at that time.

Mr. KENNEDY. You just said to me that you had heard from them first, right?

General BLANCK. Uh-huh.

Mr. KENNEDY. You are saying that you only heard from 250?

General BLANCK. No. I heard from, oh, gosh, thousands, most of which I could explain on other bases: like hepatitis, like leishmaniasis, like diabetes, like heart disease.

Mr. KENNEDY. And you stand by that right now?

General BLANCK. Yes, sir.

Mr. KENNEDY. That all of those thousands of reports that have responded to, the proposals that Mr. Evans provided to establish this Persian Gulf registry, all but 250——

General BLANCK. No, sir. I am sorry. No. Of course not.

Mr. KENNEDY (CONTINUING). Are explained by these other rationales?

General BLANCK. No. At the time I told you the 250 number, that is all I knew then. I know of far more now that I can't explain.

And even then I emphasized that I know I don't know a lot of them. In fact, I have several from your State who I have personally called and talked to and tried to help out and find out information.

Mr. KENNEDY. I appreciate that, General.

My point is that you, in a joint letter that you signed with Secretary Aspen, government officials estimated that the scope of the unexplained Persian Gulf illness stated that there were only 250 personnel in the category of mystery illness.

And you said that you have known of all of these people. And all I am saying to you is, good God, General, we were hearing from literally hundreds and thousands of these soldiers.

And so, again, it creates an impression that you were not up to speed on what was going on within the armed forces on the kinds of complaints that we continue to hear about.

And, you know, again, it is sort of spilled milk; but the point is that there doesn't seem to have been the kind of energetic response to this illness that we saw in response to Saddam Hussein by any stretch of the imagination.

Thank you, Mr. Chairman.

Thank you, General.

Mr. EVANS. The gentleman from Alabama, do you have any questions?

Mr. BROWDER. No.

Mr. EVANS. General Blanck, let me proceed on some other issues that I think are important at this time.

We have had a number of families of Gulf veterans experiencing, we believe, a disproportionately high number of miscarriages, some of whom I would assume went through military hospitals for prenatal care and so forth.

Have you collected any data on this? Have you investigated this issue?

General BLANCK. Yes, sir. In early 1992 through mid–92, we collected the data on incidents of miscarriages, the percent of miscarriages in those individuals who had deployed to the Persian Gulf area compared to the same population—not necessarily the same people but the same population before deployment, and were unable to find any difference in the incidents of miscarriage. It is about 8 percent in both cases.

Now, I cannot tell you that there might not have been an individual exposure to something that would have led in an individual case to a miscarriage. But overall, the rate did not appear to increase. I have not done that since that time, and we will pursue that as well.

Mr. EVANS. In response to a request submitted following the June, 1993 hearing, you stated, quote, "Much of what is known

about MCS today is largely anecdotal and unsubstantiated by well-controlled research.

I doubt that the mainstream medical community in the U.S. or DOD will accept MCS as a legitimate diagnosis until more research has been published in medical literature."

I understand that there is now research supportive of this diagnosis. Is that correct?

General BLANCK. Yes, it is. And that continues to be a struggle in the DOD disability agencies as to how to deal with this. We are working very closely with the VA in trying to come up with some standardized way of addressing it, and I suspect that the diagnosis of multi-chemical sensitivity, as a basis for disability, will be put on hold until we come up with more standardized ways of testing, using the SPEC scans or other diagnostic modalities.

Some of the other studies referred to may well be ways of getting out this also.

Mr. EVANS. General, I have numerous other questions that I would like to explore with you now, but because of time constraints, we are going to have to move on. We appreciate your testimony.

The gentleman from Alabama doesn't have anything else?

Thank you very much General Blanck.

Your responses to the submitted questions will also be entered into the record.

(See p. 243.)

General BLANCK. Thank you.

Mr. EVANS. To accommodate VA witnesses, we will recess until 3 o'clock.

[Recess.]

Mr. EVANS. We will now reconvene.

We are especially pleased to welcome VA Secretary Jesse Brown. We know it's been a long day for the Secretary. We appreciate his going beyond the call of duty to be with us this afternoon.

He is accompanied by Dr. John Farrar, Dr. Susan Mather, Dr. Susan Ritter, John Vogel, and Mary Lou Keener.

The prepared statement submitted by the Department will be made part of the hearing record, without objection.

Secretary Brown, you may proceed when you are ready.

STATEMENT OF HON. JESSE BROWN, SECRETARY, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DR. JOHN T. FARRAR, ACTING UNDER SECRETARY FOR HEALTH; DR. SUSAN H. MATHER, ASSISTANT CHIEF MEDICAL DIRECTOR, ENVIRONMENTAL MEDICINE AND PUBLIC HEALTH; DR. SUSAN RITTER, PH.D., MPH, PERSIAN GULF FAMILY SUPPORT PROGRAM COORDINATOR, PERSIAN GULF HEALTH ADVISORY CLINIC CO-DIRECTOR, VA MEDICAL CENTER, BIRMINGHAM, AL, R.J. VOGEL, DEPUTY UNDER SECRETARY FOR BENEFITS; J. GARY HICKMAN, DIRECTOR, COMPENSATION AND PENSION SERVICE, VETERANS BENEFITS ADMINISTRATION; AND MARY LOU KEENER, GENERAL COUNSEL

Secretary BROWN. Thank you very much, Mr. Chairman.

Mr. Chairman, I want to thank you for giving me this opportunity to discuss the health problems of Persian Gulf veterans. I want to start by emphasizing one key point.

While there may be many questions about the causes of health problems of some veterans, there is no question that many of our veterans are sick and need help. We have seen the statistics and we have heard the personal stories of Persian Gulf veterans who are suffering, and I suggest, sir, that we must be responsive.

Mr. Chairman, I have been deeply moved by what I have heard and what I have seen. Veterans are suffering from cancer, chronic fatigue, memory loss, painful joints, and other physical and psychological problems. That is why I made this issue a top priority from the beginning of my administration. That is why we are doing everything possible to help those who are suffering right now while we continue to look for more complete scientific answers. And that is why we will give veterans the benefit of the doubt on all questions about problems that may be related to service in the Persian Gulf.

Before describing the steps VA has taken, let me comment on the recent news concerning the presence of chemical agents in the Gulf. The level of public concern was raised following recent reports that an allied chemical detection unit found traces of nerve agent and mustard gas during the war.

The VA and Congress must rely on the Department of Defense for information about what occurred during that war. But at the same time the VA has a responsibility to remain sensitive to the concerns of our veterans. So we have had an open mind from the beginning. Our search for answers has never, never ruled out chemical agents.

On October 7th, 1993, 3 weeks before learning of DOD's investigation of the Czech's report and announcing an expansion of our research efforts, I noted that one of the growing concerns over the health consequences of Gulf service was chemical warfare agents. I said at that time that we must do everything that we can to get answers.

On November 1, 1993, the Birmingham VA Medical Center was selected to review the scientific literature on the effects of such chemical agents. They are developing a specialized neurological examination protocol involving Persian Gulf veterans from Alabama and Georgia and will serve as a focal point for chemical agent studies.

People have asked whether our veterans are suffering because Iraq used chemical agents or the U.S. bombing of weapon sites might have released such agents. Some are dismissing this possibility because only low levels of chemical agents were detected, the winds were blowing away from our troops, and there were no human or animal effects notable around the chemical facilities we bombed.

Mr. Chairman, let me state the VA's position on this debate. We have never dismissed this possibility and we will not prejudge this issue. We will pursue all scientific avenues until we have conclusive answers.

Mr. Chairman, my prepared testimony presents a description of the VA's many initiatives already underway or soon to begin. We

are actually proceeding on three tracks at the same time, but our priority must be in the area of providing help now.

Immediate medical care is the first track. I have instructed all VA medical facilities that Persian Gulf veterans are to receive priority care. I have directed that VA staff be sensitized to the seriousness of these veterans complaints and that they be treated with sensitivity, compassion and dignity. I will accept nothing less.

As you are aware, VA has proposed legislation to provide special eligibility for care of Persian Gulf veterans. This important legislation was favorably acted upon by this body, and I hope, Mr. Chairman, that it will be enacted before the end of this session.

The VA also provides special treatment for Persian Gulf veterans with unusual symptoms which cannot be diagnosed. These veterans are referred to one of three special centers in Washington, LA, and Houston.

We have now modified our benefits program for Persian Gulf veterans. Priorities given to veterans with claims for disability due to exposure due to environmental hazards, and I am pleased to report that for the first time criteria have been established to grant service connection for chronic fatigue syndrome. We are also providing pension benefits to veterans who are unable to work due to illness.

Our second track involves using our resources to find answers to these very complex questions. In 1991, the VA established the Persian Gulf Registry. The 10,800 veterans now in the Registry have been provided a comprehensive physical examination, baseline laboratory tests, and other tests when indicated. We are closely monitoring the Registry to identify any pattern of illness or complaints, and we are now implementing several improvements in the Registry as recommended by OTA.

Early this year, we established a Persian Gulf Scientific Panel composed of experts in environmental and occupational medicine. We have chartered this panel as a permanent advisory committee, and these experts from both inside and outside government will continue to advise us on diagnosis, treatment and research of Persian Gulf related health conditions.

Finally, I want to comment on our research program. President Clinton has designated VA as lead agency for all Federally funded research into the health effects of the Persian Gulf War. I have asked the heads of Defense, HHS, EPA to assist VA in this effort, and recently VA awarded a contract to the National Academy of Sciences for an independent review of the possible health effects of the Persian Gulf service.

At the recommendation of a VA working group that included our national veteran service organizations we will be establishing our own research centers. Each center will include scientists specializing in the study of toxic and environmental hazards.

Mr. Chairman, we are doing everything that we think is possible and reasonable, and we are open to suggestions from all concerned. If you, Mr. Chairman, or any other member of this committee, or anyone else, believes that we should be doing something that we are not doing, we want to hear from you. Please, please let us know.

Mr. Chairman, in closing, I want to make it very, very clear that this Secretary for Veterans' Affairs does not intend to repeat the

mistakes made in the past with respect to Agent Orange, ionizing radiation, LSD, and mustard gas. I am reminded of Maya Angelou's poem in which she said, "History despite its wrenching pain cannot be unlived, but if faced with courage need not be lived again." We must not allow history to repeat itself.

The veterans who served in the Persian Gulf did not hesitate to put their lives on the line for this Nation. Now, this Nation must not hesitate to carry out its moral obligation to them, a moral obligation to put veterans first.

Mr. Chairman, this concludes my statement. I would be pleased to respond to any questions that you may have.

[The prepared statement of Secretary Brown appears at p. 211.]

Mr. EVANS. Thank you, Mr. Secretary.

First of all, let me say several of the veteran service organizations in their testimony and several of the members of this committee and the Armed Services Committee have already publicly stated that we appreciate the quick action and appropriate action that you have taken since this information from the Department of Defense came to you.

Your action is clear contrast to where the VA was many years ago when we were fighting to obtain help for veterans suffering from Agent Orange. Today, the attitude is different, but so is the action, and that has been noted by many of us on the committee and in the veterans community. So thank you very much for that attitude and that approach.

Secretary BROWN. Thank you, sir.

Mr. EVANS. We do have some problems, however, that some veterans have raised in terms of the VA's response. I think it has been an overwhelming problem in certain facilities. Last week several veterans reported waiting many months to have VA's Registry examination. In fact, some indicated that appointments in their local facilities were being scheduled for late 1994 and early 1995.

Can you tell us what the VA is going to do to conduct these Registry exams in a more timely fashion and which medical centers are making veterans wait 30 days or more for this exam?

Secretary BROWN. We do have that information, Mr. Chairman. I think before I ask Dr. Farrar to respond it is important to state that when this issue was brought to my attention one of the things that we wanted to do was to take immediate proactive action and to sensitize, as I stated in my prepared remarks, our staff that these veterans deserve immediate attention.

And, as you know, we are experiencing some problems because of our timeliness, not just on Persian Gulf veterans. I think it is only fair for the record to state that a large percentage of people who are requesting assistance from the VA have to wait 30 days—anywhere from 30 days to 200 and some days to gain access into our system, primarily as a result of lack of resources.

If you look at the VA's budget historically, there is no question in my mind that we have been underfunded and now we are seeing the results of that. That result is the same—the same pattern exists on the veterans benefits side. Our timeliness standards are deteriorating, or have deteriorated. Our backlog continues to deteriorate, although we are beginning finally to make some headway in that with our modernization program.

But I am going to ask Dr. Farrar to respond to that particular question.

Dr. FARRAR. Mr. Chairman, I think we have had a problem in the VA of long waiting times. Let me address the two parts: one, the long waiting times in general, and more specifically waiting times for the Registry.

On November the 1st, I sent out a memo to all directors of all hospitals urging them to address these veterans with sensitivity, dignity, caring and compassion and arrange appropriate diagnostic work-ups with qualified specialists in a timely fashion. That word has gotten reinforced on our conference call as well as this hearing, and we will follow up, and if you would like we'll get back to you with how fast the centers are responding.

On the more general problem of waiting times, that is one of our problems and we are addressing that. The IG has called this to our attention with considerable force, and I believe that relatively soon we will see more timeliness in our waiting times for all our patients.

Mr. EVANS. I take it you must be somewhat frustrated with the Department of Defense in regards to the Czechoslovakian report. I know we are on the committee, and I think the families are agonizing over that late information that they received.

But hopefully, looking to the future, do you think that DOD will be forthcoming with all the intelligence data that it has on a variety of potential different environmental exposures? Do you feel there is good cooperation and information sharing concerning possible biological or chemical exposure to our veterans at this point and in the future?

Secretary BROWN. We have—I might add for the record that Secretary Aspin is a man of integrity. I think that he is moving forward in a manner that he feels is consistent with his mission and based upon the facts as presented to him.

At the same time, I think that we have to make our own decisions based upon the facts as we see them, and sometimes those courses may run parallel or may, in fact, run in opposite directions.

I say that simply to say, Mr. Chairman, that we are going to move forward based upon what we think is best for veterans. Even before the revelation that the Czech unit detected low concentrations of chemical agents in the Gulf, the VA had taken action that we were going to look for chemical agents primarily based upon all of the complaints that we have received from our veterans across the country.

Likewise, we are going to move forward even though the Department of Defense has basically stated that they see no relationship between those so-called low levels, low concentration of chemical agents and the complaints that our Persian Gulf veterans are suffering from.

We are moving in a different direction. We are going to let the science determine whether or not there are any relationships and that is why we are setting up a screening process, a protocol process at our VA Medical Center in Birmingham, AL, to help us to design the right approach, and that is why we are moving forward, quite frankly, with our three research centers where we will be em-

ploying the best minds in the country both inside and outside of government, sir.

Mr. EVANS. I was able to visit Birmingham VA Medical Center over the weekend at the request of my democratic colleague from Alabama and Republican colleague from Alabama, Mr. Bachus, and we are really pleased with the action you have taken there. It is a good facility, and I think it shows bipartisan support for what you are doing, and we are very encouraged.

Also, we are encouraged now that the Seabee unit that has been having so many problems apparently is going to be visited by a Navy team as well. I think that is something the Department of Defense should have done months ago, but it seems to be a significant step forward.

I have more questions, but I will yield to my colleague from Alabama, Mr. Bachus, at this time.

Mr. BACHUS. Mr. Secretary, how would you characterize the cooperation between you and the Department of Defense over the Gulf War illnesses? Has it gotten any better?

Secretary BROWN. Well, I think, as I mention in my statement, we have to rely on the Department of Defense for information. We do not have independent access to that information, just like the Congress. And I think everyone is waiting for all of that information to be made available, and we are too. And I think that we on a number of areas, however, we are operating at a level that is very cooperative in nature.

Mr. BACHUS. Okay. Does the VA recognize multiple chemical sensitivity as a diagnosis?

Secretary BROWN. No, sir. We do not recognize multiple chemical sensitivity syndrome as a diagnosis. However, what we have done, we have made a bold step forward in the sense that we have just established a criteria which is ratable under—number one, is ratable as service connectible and is also ratable under our rating schedule for fatigue syndrome, and that is new.

But at this point in time we do have—and I am going to ask Dr. Mather to respond to that. We do have people looking at this so-called Persian Gulf syndrome to see whether or not it has the nature and the character that will allow us to define it as a diagnostic entity.

Dr. Mather.

Dr. MATHER. Well, I think one of our plans is to get a consensus conference together of scientists around the country to talk about more than just multiple chemical sensitivity, because that is really a broader problem than just the Persian Gulf veterans. That is a somewhat controversial label in the scientific community at large. We will ask the consensus committee to look at the Persian Gulf illness or Persian Gulf syndrome, as it has been labeled, and to come up with some consensus about that. But I think in order to be accepted as a diagnosis there have to be criteria for the diagnosis that are agreed on by the larger scientific community.

I think the Secretary referred to having chronic fatigue syndrome now as a diagnosis for which disability can be determined, and that's been controversial for the last 20 years at least, what the cause of it is. At least now there is an agreed upon list of criteria that CDC agrees on, NIH agrees on, and the infectious disease

community has sort of agreed on for the diagnosis of chronic fatigue syndrome.

We are not quite there yet for multiple chemical sensitivity, however, but I think there is going to be a lot of work in this next year on that to see if we can come up with something that everyone can agree on, or at least a majority of the scientific community can agree on.

Mr. BACHUS. I guess part of my question is has the Department of Defense actually discharged some active duty personnel with that diagnosis?

Secretary BROWN. Yes. In fact, I think there were six so-called, six such cases and I asked Mr. Vogel to do a complete review of those cases, and I think that we can respond to that.

John Vogel.

Mr. VOGEL. Thank you, Mr. Secretary.

We had heard there were six discharges for multiple chemical sensitivity. We reviewed all of them and there was only one discharged that way. The President of the Army Medical Evaluation Board said that was an error and a departure from the policy they had established.

Mr. BACHUS. You mean on the other five or on all of them?

Mr. VOGEL. No. On the one that they did say had multiple chemical sensitivity as a disability for which one could be, in fact, discharged from the service. We reviewed all of those.

Most of them had a direct service connection, as we call it, for a known disability incurred while on active duty, which rendered a few of them unfit to continue on active duty. One was a sensitivity to rubber, as an example, where the individual couldn't wear the protective gear. Another was a respiratory disorder. A few others had a fatigue syndrome of some kind that resolved and they continued on active duty, in fact.

So, the long answer to a short question, Mr. Bachus, one case of discharge for multiple chemical sensitivity that the Department of the Army says was a mistake.

Mr. BACHUS. I maybe should wait until everyone has offered the testimony they are going to give—are we at that point now?

Secretary BROWN. Yes, sir.

Mr. BACHUS. Let me ask you this. Are you aware, Mr. Secretary, that Dr. Hyman has received an appropriation?

Secretary BROWN. Yes, of 1.2 million.

Mr. BACHUS. And we have had some testimony earlier today that causes me to think some of what he is doing is similar to some of what you are doing, studying whatever this condition is, or these conditions. Is he cooperating with you, or how do you plan to sort of plug in with that program?

Secretary BROWN. We have a long history with Dr. Hyman. As you know, he was initially brought to the attention of the Department because he was treating some veterans, I think, with massive doses of antibiotic which he said resulted in a cure.

We had a special team, and Dr. Mather herself talked with him on a number of occasions, asked him to share that information with us so that we could take a look at it. Obviously, we did not want to adopt something that could ultimately end up being harmful to our veterans, so we wanted to look at it very, very carefully before

we decided that we wanted to do anything and he would not cooperate with us at that point.

But I want to say this here, sir, that that is very important to me. Is that this issue here is so complex that we are willing to look at everything that is available. And now, hopefully, since he has this appropriation he will then have to document his findings, and, of course, we will have access to that information.

And I might add I want you to know that we are willing to cooperate with him in anyway that we possibly can. I am going to ask Dr. Mather if she has anything else to add to that.

Dr. MATHER. Only that the staff at the New Orleans VA Medical Center has been working to try to develop a protocol with Dr. Hyman that could be submitted to the Human Subject Subcommittee because we have to protect human subjects. And, as far as I know, Dr. Hyman is working on that protocol and has not yet gotten back to the staff in the New Orleans Research Service.

Mr. BACHUS. Our office has worked with him since a lot of the veterans are from my area, and Representative Livingston's office, and he has assured us that he wants to cooperate with the VA in this program and share all the information, and I would like to know whether that is being done. It could be a significant expenditure and we could miss a lot of benefit if we don't know how that program is doing and the benefit.

Dr. MATHER. We will certainly be very interested in the result.

Secretary BROWN. I am willing to commit further than that at this point, sir. We will make it a point, as a matter of record, to contact him to see if we can arrange a medium by which we can exchange information.

Mr. BACHUS. And you know I am as concerned about his cooperation as I am about yours. I am aware of your long history, and I would think it would be a shame if this program didn't go forward in a cooperative manner.

I just want to commend you on the pilot program in Birmingham. It is receiving high marks from the veterans there, and I just want to congratulate you on something that you have done that I think is a real accomplishment.

Dr. FARRAR. Dr. Ritter, at the table, is the co-chairman of that group.

Mr. BACHUS. I knew that. We met together Friday, and she has done a great job.

Thank you.

Mr. EVANS. The gentleman from Alabama.

Mr. BROWDER. Thank you, Mr. Chairman.

Secretary Brown, I would like to ask you a couple of questions, and anybody else, Dr. Farrar or anybody else jump in if you see fit to.

Secretary Brown, first let me congratulate you on the VA's—the Veteran Affairs Department's—willingness to be responsive on this. I know this is a very difficult position for the Department to be in, but your willingness to be responsive and moving ahead with the pilot program down in Alabama. The three of us visited there last week, and we are impressed with the good faith effort that you are making there. I would like to ask you just a couple of questions.

You have said that—you have noted that you have to rely on the Department of Defense about information about what occurred during the war, but at the same time you have a responsibility to remain sensitive to the concerns of veterans. You have an open mind. You also say that you will—we have never dismissed this possibility of exposure, chemical or biological exposure, and we will not prejudge this issue. We will pursue all scientific avenues until we have conclusive answers.

What conclusive answer do you need about possible exposure? What conclusive answers are you pointing to there?

Secretary BROWN. I think the statement there has two significants here: One is that it was meant to say that while the Department of Defense has said, or admitted that low levels, low concentrations of chemical agents were detected, however because of wind direction, because of the low levels, because there was a lack of dead animals in the path, there is no relationship between that concentration and the complaints that Persian Gulf veterans are having.

I basically reject that. That doesn't mean anything to me, and so that is—I was trying to say that in a very diplomatic way, because I believe that that is a question that will be ultimately, in my judgment, resolved by the scientists. I mean, to me it is just a statement, and I think that we need to look at this here very, very carefully.

We saw evidence of this kind of problem in our efforts to deal with Agent Orange. We saw it in our efforts to deal with the adjudication of ionizing radiation. We saw it with LSD, and we saw it with mustard gas. So all of that is nothing new to us.

So what we want to do is, we want to look at this thing from a rational standpoint and to try to find some answers. That is one of the reasons why we are investing very, very heavily in research. We are not only setting up the center down in Alabama to try to help us develop a protocol, right now we are in the process of setting up at least three research centers that are going to be staffed by very——

Mr. BROWDER. Excuse me, Mr. Secretary. If you don't mind. My chairman is going to be turning my light off in just a minute.

Let me ask you, you say you are not going to be satisfied until you have conclusive answers. Is the conclusive answer an analysis of the problems that these people, veterans have and how to deal with them, or is the conclusive answer answering the question of whether or not they were exposed to chemical or biological agents?

Secretary BROWN. I think they are probably interrelated. We are on basically two tracks. The fist track, of course, is to deal with the problems that we are having right now, so we want to provide quality health care to deal with the manifestations and the complaints that veterans are bringing to us. A veteran comes in complaining of a skin disorder, we want to be able to treat that and resolve that if we can.

The second is that we need to look at the etiology of those complaints. What is the origin of the complaint? And that is one of the reasons why we are putting a lot of money in the Birmingham Medical Center, to see if we can identify what is the origin of the complaints.

Now, if it so happens to be deficits as a result of exposure to chemical or biological agents, then so be it.

Mr. BROWDER. Is that conclusive answer, is that a responsibility of the Veterans Affairs Department or of the Defense Department or both?

Secretary BROWN. Well, we believe that—and we take it personal, that we want to make sure that if a veteran is hurt as a result of carrying out the policies of the United States Government that we believe that it is our responsibility to do everything that we can to make sure that he receives his entitlement.

Mr. BROWDER. Okay. Well, let me move on. One final question. What problems does—the present Department of Defense position on that question, what problems does that create for you, if any?

Secretary BROWN. I guess it doesn't create any problem. It would have been nice to—I guess it doesn't create any problem with us right now because we are going to move ahead. What we would like to do is we would like to move ahead together, if they will cooperate with us and put some money into the research projects and so forth, and I think they will.

Mr. BROWDER. Can we get the help that these veterans need and deserve if the Department of Defense maintains its current position? Can we get that help and will it be slowed up if the Department of Defense maintains its current position?

Secretary BROWN. That is one of the areas that we are very concerned about. It took us 20 years to adjudicate Agent Orange. It took us probably 30 or 40 years to get to the bottom of the question dealing with mustard gas. It took us in some cases 20 and 30 years to find out what happened to these veterans that were suffering from the effects of LSD.

We don't want to wait that long. We want to profit from the history here.

Mr. BROWDER. I think I understand the gentleman's answer.

Mr. Chairman, if possible, I would like to return at some later time to probe that because I think that is very important for our other committee that we are working on.

Mr. EVANS. We will come back to you after Mr. Collins, who is now recognized.

Mr. COLLINS. Thank you, Mr. Chairman.

Secretary Brown, I do want to say how much I appreciate Dr. Mather and Dr. Roswell and Jimmy Clay, Tuskegee and Birmingham, coming by the office 2 weeks ago today and addressing a lot of the questions and concerns of the group of veterans from the Columbus area, and we are pleased to know, as we were informed that day, that in the pilot program there will be testing for the HTLV—1 and 2, lymphoma cancer, and will be doing some consulting with those families, which we think are all very important.

If I can follow up on Mr. Browder's question about the working together, the team work of the Department of Defense and your office, are you having a lot of conversation about this, or is it a one-sided, "want to do" deal? Is the Department of Defense actually communicating with you on establishing the team work, working together as you would like to see?

Secretary BROWN. We have. I think we have set the framework in which to move forward. In fact, we wrote to them on a number

of occasions asking them—we wanted, in fact, we asked them for some money, because I think it is—the way I view this, some might say that once a veteran becomes a veteran, then it is the VA's responsibility.

But I think it is in everyone's best interest that we try to get to the bottom of exactly what occurred there. It is in the best interest of the national defense. I don't think that it serves our Nation very, very well when people come out feeling as if they have not been treated fairly.

So if that is the case and you buy into that particular standard, then it seems like to me that the Department of Defense and everyone else would want to try to resolve this matter as quickly as we can. We have offered, and I know that we are working very, very closely with the Department of the Army and the Department of the Navy to try to help us move forward, and I am encouraged about what is beginning to take place.

Mr. COLLINS. Have you had any positive responses to your letter, especially the money portion of it?

Secretary BROWN. No. That went over on October 8th. You know, it is a big organization and I am sure that we will hear from them.

Mr. COLLINS. I expect you will have some help with that one.

Okay. I was notified just, I believe it was Friday or yesterday that the team going down to Columbus has invited a VA person to attend that with them. But yet I don't believe you have had the invitation to go to Al Jubail with them, is that not true? Or do you know?

Ms. RITTER. I am not aware of it.

Mr. COLLINS. Mr. Chairman, that is all I have.

Thank you very much.

Mr. EVANS. Thank you. I will now yield my time to the gentleman from Alabama.

Mr. BROWDER. Thank you, Mr. Chairman.

Mr. Brown, I would like to go back and pursue that. Could you answer me again, is there—can these veterans get the help that they need and deserve as long as the Department of Defense, if its current position were to be its absolute forever position and—well, let's just start with that one.

Secretary BROWN. I would say yes, and that is because we are going to do whatever it takes to resolve it. Regardless of whatever happens in the other area, we are going to do what we think is right. So, I think it is going to be resolved, and if it has to be resolved by the VA and VA alone, then so be it.

Mr. BROWDER. Would it help in getting this help for our veterans if the Department of Defense had a change of position? I am not asking them to say something that is not true, but they are saying, they are emphasizing as of now, based on what we know, we cannot document or confirm any exposure or the presence in any significant amounts of agent, and we cannot say that any of the problems that the veterans are having were caused by exposure to these agents.

If they were to just move forward and say we have documented or we have reports by the Czechs that there were agents present—we cannot independently confirm that but we have checked them out and we believe that they did detect what they think they de-

tected; if they acknowledge that there are reports from a lot of veterans that they were subjected to chemical agents; if they were to say that we have a lot of veterans with problems that that fit the profile for—that are not incompatible with chemical or biological exposure, we cannot confirm the presence of chemical or biological agents nor can we deny those agents, period—would that assist, would that much of an acknowledgment by the Department of Defense help in getting these veterans the care that they need?

Secretary BROWN. It was my understanding that is exactly their position. They are saying that the Czechs detected low levels of concentration, they sent a team over there to look at the equipment, to look at the personnel that were trained to use that equipment, and they have said that we move forward on the assumption that there were indeed chemical agents detected. We cannot verify this through independent sources.

However, they went one step farther, which I think is very good. They are going to set up some kind of panel to continue to research that.

Mr. BROWDER. Mr. Brown, you are being very kind to the Department of Defense. They did say what you are talking about, but that kernel of fact is mixed in a big bowl of a lot of virtual denials. They make that one statement and then they go on and say, virtually, that we don't think there is any connection between what these veterans are saying now and any possible presence of chemical or biological agents. They go that step forward and then they come back and say but we are continuing to investigate that.

I guess it is an attitude that I am concerned about, and I would like to ask is that mixture of attitudes a problem to you in getting help for veterans?

Secretary BROWN. Well, I think that—to me it has more to do with what we are trying to ultimately achieve. There are many, many veterans out there that don't know what is wrong with them. But I think most people, you know, if you go to the doctor and you have a pain or something, you want to know what is wrong with you. And. If he tells you, "Oh, it's just an upset stomach," then you are much relieved because you know it is not cancer. So there is value in bringing forth all of the circumstances surrounding your complaints, because probably by and large most of the folks would be very happy with the results.

But I am going to ask my General Counsel to help me out in responding to that.

Ms. KEENER. I was going to suggest maybe Mr. Vogel would help us out with that. [Pause.]

Mr. BROWDER. Is anybody going to help us out with that?

Mr. VOGEL. I think that, you know, we talk about the cooperation of DOD. My staff and subordinate staff have been dealing with the Army Evaluation Board folks and what not. Our concern from the benefits point of view is that we have the medical tools available, diagnoses, what the condition is, and whether we can in fact provide disability compensation. I don't see any impediment, especially with the pending legislation. It allows VA to treat Persian Gulf veterans on a priority basis. No impediment to the VA's care for them medically.

I am not a doctor, but I think the VA's response has been very vigorous. Nobody needs to pat the Secretary on the back, but his number one and only concern is veterans, and I think perhaps the Department of Defense seems to be distracted. When they are no longer on active duty they are maybe not quite as important to them as they are to us. They are the number one for Jesse Brown. And I think we are doing what can be done. We need the answers. The best way to treat people medically is to know what the underlying condition is so that you can provide a regular treatment protocol.

Dr. Farrar.

Dr. FARRAR. As a physician, I want to respond to Mr. Browder. I think that I want to support Secretary Brown. I don't really think it makes any difference, Mr. Browder, what the DOD is now saying.

Secretary Brown has had the feeling all along, as have we as physicians that anything is possible, any combination of biological and chemical and anything else. So we are looking at all possibilities and not ruling out anything. So, it really doesn't make any difference what the specific words are that are used by the DOD. We are looking at everything. And I think that is the way to go.

Mr. BROWDER. Mr. Chairman, I guess the reason why this is important is for those of us who are going to be looking at it on the defense end of it, side of it, we have to be concerned about why in our mind the Defense Department is not being forthright in addressing this issue, and I just wanted to illuminate the possibility that they would be doing so because they don't want the financial liability of providing this service, this help to veterans.

Apparently, if this help to the veterans can be gained with their current position, then there must be another reason that we will have to explore with the Defense Department.

Thank you.

Mr. EVANS. We appreciate the gentleman's line of inquiry and we recognize the other gentleman from Alabama, Mr. Bachus.

Mr. BACHUS. Dr. Farrar, I read your prepared remarks.

Dr. FARRAR. Yes, sir.

Mr. BACHUS. In there you mention Sarin, the nerve agent.

Dr. FARRAR. Yes.

Mr. BACHUS. That there were some long-term effects from exposure. I know that the exposure that we know about was very low amounts, but what are the long-term effects of exposure to high concentrations of nerve agent or is it low concentrations?

Dr. FARRAR. Usually—I am going to make one very brief statement and then I am going to turn it over to the real expert, Dr. Mather. And that is that usually with Sarin there are acute effects, and it is unusual—but I am not an absolute expert on this—it is unusual to have long-term chronic effects without having had some acute effects. But we do have a list of symptoms, but let me leave that to Dr. Mather.

Dr. MATHER. I think one point that needs to be made is the Department of Defense has expressed an opinion based on what is available in research, that it doesn't have any long-term health effects. We, I guess, in VA have become somewhat sensitive to long-

term health effects of low levels of a lot of different environmental agents.

A lot of times we are not aware of what those long-term effects are because they haven't been studied. It is just that simple.

We do know, though, that Sarin is a cholinesterase inhibiting agent, and there are other similar agents where we have been able to study long-term health effects, particularly in pesticides. Pesticides are also cholinesterase inhibiting agents.

And so what we have said is that if we don't have a necessary literature at our disposal now let's look at what we do have and say, "If this were the case what will we expect to see in these veterans?" If they had been exposed to a cholinesterase inhibiting agent and it had been significant, and we don't know what significant is, but if it had been a significant exposure what would we expect to find 3 years later? And there is evidence that peripheral neuropathy can be detected in people who had exposure to cholinesterase inhibiting agents; that these kinds of subtle cognitive defects—the difficulty with memory, the trouble concentrating—these things can be documented with objective neurobehavioral tests and that is what we are looking at in the veterans.

I think if we do pick up these symptoms, or these signs, in a large number of people who were in the same place at the same time, then we will have to look at shared experiences. What kinds of exposures did they have?

But since we can't determine what happened in the Persian Gulf 3 years ago, there is no way we can do that in VA, all we can do is take the veterans and look at them. Then if we find objective findings, go back and look for shared experiences in a control group to study that.

But I think where you don't have scientific literature, (and I think what the military is saying to us is we don't—) it's our opinion, based on what we have got, that this is not a problem. Our response is maybe what you have got isn't enough and we need to be looking at this further, and that is the approach we are taking.

Mr. BACHUS. Let me ask one or two other questions, if I could. The study that Dr. Miller is going to do at the University of Texas, when do you think that study might be completed? I know the appropriation hasn't been made. But do you have any idea when we can get a report back? What kind of timetable are we under there?

Secretary BROWN. Yes. He said the total report is going to take, the final report is going to take about 3 years, but he said we should have an interim report——

Dr. MATHER. There are two Dr. Millers we are talking about. There is a Dr. Miller with the Medical Follow-up Agency.

Mr. BACHUS. Claudia Miller.

Dr. MATHER. But Dr. Claudia Miller is at the University of Texas and she has a proposal for an environmental unit.

Mr. BACHUS. And that is funded in the defense appropriation?

Dr. MATHER. And as I understand, there is an appropriation pending in the Defense Appropriations.

Mr. BACHUS. That is right.

Dr. MATHER. As I recall from her proposal, it would take about 6 to 9 months to get the unit up and going because it will require some building modification, and then the studies would begin at

that point, and it probably would be a year at least. So, we could possibly be seeing some results in 18 months following the funding.

Secretary BROWN. Why don't you go ahead and tell them about the other Dr. Miller now.

Dr. MATHER. The NAS is doing an epidemiologic review about which they testified on the Senate side. That is a 3-year study and we will probably have an interim report in 18 months. That is the other Dr. Miller.

Mr. BACHUS. Other than those programs, are we studying Dr. Shayevitz's proposal which she testified about?

Dr. MATHER. That is a proposal for a clinical unit, but it has no research base, and the decision has been made to look at this in a research mode rather than in a strictly clinical mode.

Mr. BACHUS. The thing that I think attracts me about her program is we would start treating people immediately. Are we doing that now in a specialized setting?

Secretary BROWN. We are treating people immediately within—not timely across the board, but we are treating people for the manifestations or the complaints. By that I mean if a person comes in and he or she is suffering from a skin rash or they are suffering from some type of stomach problem, we treat that right then and there.

But that is separate and apart from the research. What we want to be able to do is to find out why is that person suffering from the skin rash, why is that person suffering from short term memory loss, and that is where the focus is going to be on research.

So, we are running two parallel courses here, both of which are very important.

Mr. BACHUS. But I guess what I visualize is a lot of veterans out there with the same symptoms, and we respond with some sort of treatment, but we don't actually have a program going where we are bringing in a number of them and treating them and following them and seeing whether it works.

And yet it is going to be 18 months before we get any report back from Dr. Miller's study and this other study you have mentioned. Are there other proposals like Dr. Shayevitz's proposal to go ahead and start a clinical program and bring our veterans in, a number of them, and start treating them?

They are telling us, they are coming to us, writing us, they are sick, they are losing their homes, and now we hear it may be even 18 months before we get the research back as to what is wrong with them.

What is your attitude about Dr. Shayevitz's proposal?

Dr. MATHER. I think there are problems in funding a proposal that involves an expenditure of approximately $2 million in the first year which will not provide any answers to the questions other than that it has helped those individual veterans. It seems that with that expenditure of money, we should be answering some questions too and not just sort of treating empirically.

There is a great desire and a need to treat empirically, but I think from a system standpoint in order to benefit more than 120 veterans or the number that would go through in a year it needs to have a research focus, and it is entirely possible that we can

work with Dr. Shayevitz to establish a research focus to her clinical program, her clinical proposal.

Mr. BACHUS. I just wrote down what I think it was Troy Albuck said when he said, "I don't really care about finding out what kind of agents were used. Why I am suffering." It's kind of like figuring out what kind of gun created the wound. He said I am not concerned about that, I just want to get better.

And we have veterans that have been sick for 18 months and some of us are sort of wondering why they are sick, but I think they are. What they are telling us is they want treatment.

And we do have to know to a certain extent what caused some of this, but I don't see the treatment waiting another 18 months.

Dr. FARRAR. May I respond to that? I think, Mr. Bachus, you are manifesting the same frustration that we feel. We desperately want to help the people we can and we don't want to wait for 18 months to get the final answer.

But, on the other hand, we can't use every possible treatment that everybody suggests, and Dr. Shayevitz, I think, has a good one, and Dr. Mather and I are going to review this and see what we can do to involve her, because it does seem very effective. But we can't use every treatment that people suggest.

Mr. BACHUS. What strikes me about Dr. Claudia Miller's proposal and what she thinks will work, what Dr. Shayevitz is talking about—I may be mispronouncing her last name, but they mispronounce mine all the time—and even Dr. Hyman to a certain extent, where he isolates these people in a fairly sterile environment. All are very similar in what they are proposing.

Dr. FARRAR. Let me assure you we will review—Dr. Mather and I will review, and the rest of the people in Central Office will review Dr. Shayevitz's proposal and work with her to do the best we can to take care of the veteran.

Mr. BACHUS. I would just hope that we could, 6 months from now or 3 months from now, have some testimony that we took a group of 20 veterans suffering from this condition and we put them in a clinical unit and we treated them and they are better or they are not.

I have my suspicions that the antibiotics have as much benefit as the fact that Dr. Hyman hospitalizes them and isolates them from toxins over a 2 or 3-week period. But they are getting better. Maybe the antibiotics are doing nothing.

If we could even put 20 veterans in and treat 10 of them with this and 10 of them a little different and have some report back in 3 months.

Dr. MATHER. Well, unfortunately, even with the environmental unit it would take us some time to get a clean unit in place. So 3 months——

Mr. BACHUS. I guess I just don't understand that. And I am not trying to be critical. I just don't understand why you couldn't have environmental units up and running now.

Dr. MATHER. I don't always understand the slowness of the construction process, but there would be some construction involved.

Mr. BACHUS. Well, I would just urge you to start treating some of these veterans in some of these programs as opposed to waiting

another 18 months before getting a preliminary report back on what we need to do. I am just concerned.

Mr. EVANS. One of the problems similar to Agent Orange is the matter of compensation. There are veterans who are coming to Birmingham, for example, at their own cost for travel. They aren't working. They don't have an ability to work because many of them are suffering and ill.

And paraphrasing the statement of the VA, since chemical and biological weapons exposures cannot be directly detected, VA would never be positively able to confirm such exposure. Given that, could the VBA compensate those veterans believed to have been exposed? Is there a reasonable association we might make to service in the Gulf with some of these problems?

If not, we are left in a situation, it seems to me, very much like Agent Orange where for years foes of any Agent Orange legislation were saying you can't scientifically prove it, that the exposure caused the condition and therefore we can't compensate it.

What would be your recommendations at this point as far as compensating extremely ill individuals that are showing the same kind of common symptoms that many other veterans have faced, who were healthy before they went into the armed forces?

Mr. VOGEL. Most who present themselves, or who come to us for disability compensation benefits—about 265,000–267,000 men and women served in the Persian Gulf, and we have had almost 27,000 claims for disability compensation.

Mr. EVANS. And how many have you awarded at this point?

Mr. VOGEL. We have awarded 7,260 of them. Most of them are receiving compensation based on a direct incurrence of something that happened to them while on active duty. A shell fragment wound, an injury to one's leg, a fire, or a jeep accident—you know, the things that happen to people.

Mr. EVANS. And I would assume, Mr. Vogel, that most of the awards have been made on that basis?

Mr. VOGEL. Most of the awards, yes. Now, we have received about 2,500 claims from veterans for environmental illnesses, usually describing respiratory disorders, skin conditions, and what not.

Mr. EVANS. 2,500 claims.

Mr. VOGEL. Beg pardon?

Mr. EVANS. There have been 2,500 claims.

Mr. VOGEL. About 2,500.

Mr. EVANS. And how many have been——

Mr. VOGEL. And about half of them have been adjudicated. Most have been denied. We don't find a disability when we do the examination. In some cases, like you have indicated, Mr. Chairman, we don't find a cause for something for us. We have symptoms but no clinical findings. We have only had, on purely environmentally induced illnesses, about 79 cases where we have granted a service connection for them.

It would seem that the agents used, if they were, have a fairly well-known cause. We just need to get the answer from the medical people how, and that is what Dr. Mather so well described a few moments ago. We have an answer about what the long-term causes are of the exposure at whatever level.

We have no more problem from the disability compensation point of view. We simply provide the compensation at the appropriate amount based on how disabled the individual is, and we have done the right thing there.

Mr. EVANS. Can you supply to us the breakdown of the particular ratings of those 79, 10 percent, 20 percent, and maybe you can provide us information today about the claims for disabilities due to exposure to environmental hazards which have been approved?

Mr. VOGEL. I can provide that for the record. Most of them are respiratory and gastrointestinal and skin conditions.

Mr. EVANS. If you could provide the information to us I think it would be very helpful.

[The information follows:]

SERVICE-CONNECTED DISABILITIES BASED ON EXPOSURE TO ENVIRONMENTAL HAZARDS

As of January 12, 1994, 163 veterans who filed claims for disabilities they believe resulted from exposure to environmental hazards have been notified of favorable decisions. Service connection has been granted for one or more disabilities because evidence in these veterans' records indicate their conditions were related to their military service.

The attached is a summary of the findings.

BODY SYSTEM	NUMBER
Lower Respiratory (LUNGS)	77
Skin	35
Upper Respiratory (SINUS)	18
Digestive	13
Headaches	10
Eye	4
Hemic/Lymphatic	4
Systemic	3
Cardiovascular	3
Genitourinary	3
Neurological	3
Psychiatric	3
Musculoskeletal	2
Ear	2
Endocrine	1

Mr. EVANS. I think we are in a very difficult situation trying to help so many of the veterans who have come to testify and the people that we have met in Birmingham continue in the programs that we have set aside. If they can't get some kind of economic compensation soon, I think many of them will have to drop out of that kind of treatment program.

I understand the situation that you are in, but we are going to have to be making some decisions sooner or later on this committee as to where we go next. I don't have any answers myself, but we will need your help in making that decision.

Do you have any recommendations for us at this point in trying to look forward to compensation legislation?

Mr. VOGEL. I don't have anything at this time, Mr. Evans. The Secretary and I were discussing it the other day. We will be, of course, pleased to work with you. We know where you are coming from on it. We want to work with you.

Secretary BROWN. I have just one brief observation to make, Mr. Chairman. I think you asked the right question there. There is no doubt in my mind that the greatest tragedy here is that when you have a veteran who for whatever reason is unable to obtain and maintain substantial gainful employment for something that he feels or she feels that happened to them while they are in the service, and there is no way that they can prove it, or let us just take for illustration purposes, let us say, for instance, a veteran served in the Persian Gulf and he has short-term memory loss, but he didn't complain of anything in the military and he probably didn't even have his first manifestation until maybe a year after he got out.

Well, that makes it very difficult. Number one, it makes it difficult how do you rate that? How do you verify it? How do you rate it? But at the same time it could be of such intensity and magnitude that it interferes with his ability to get on with his life.

So, clearly the question that you ask is one that needs to be looked at very, very carefully, sir.

Mr. EVANS. Do either of my two colleagues have any other questions?

Mr. BACHUS. I am going to restate something that I said before. When there was an appropriation given to Dr. Hyman, I think one of the reasons was it was the only testimony we had of a program that was working. I think we would have preferred a VA program where the VA came to us and said we have a program and we are treating people for this condition. I mean in a unit.

But all we had was Dr. Hyman, or veterans saying they had gone down there and were much better. And that is why today the only testimony we have had of a unit of this nature is of Dr. Shayevitz's unit. Her proposal is the only proposal for a unit where we start treating these veterans in a group situation.

This problem is not going to go away, and I think if we are back here early next year, Congress is probably going to try to attempt to deal with the problem. They are probably going to continue to go out of house and appropriate money for programs and treatment if the VA does not establish some sort of an in-house program dealing with this specific situation.

I am not saying that is going to happen. This is not a threat. It is not even appropriate for me to say that. It is just that I think that will happen. I think the public will demand that we move in that direction, and I think they probably should.

Secretary BROWN. I agree with you. We have no problem with that.

Quite frankly, I think that the Nation is better served when we have people from all walks of life with different resources, different perspectives on a given situation to get involved. So we agree and encourage that process. Because, obviously, if something productive

comes out of it, then we can just grab a hold of it and run with it.

But I made one statement, and that is, that if we—if you recognize or you come up with something that we are not doing that you think we should be doing to let us know. I have heard your message, and why don't you give us a chance to take a look at this particular project and let us see what we can do with it.

Mr. BACHUS. Thank you. Very much appreciate that. And that was very responsive.

Mr. EVANS. The gentleman from Alabama.

Mr. BROWDER. Thank you, again, Mr. Chairman.

Mr. Brown, one suggestion or request. I notice when we asked down at the pilot program whether they had any extra people assigned to them for this program I think the answer was zero. Isn't that right? I think it is—that just raises questions.

Dr. MATHER. I talked to Dr. Roswell last week and asked him to get us a request in for whatever enhancement, program enhancement he needed, and he said he would get on that. So we are expecting a request.

Mr. BROWDER. Okay, good. And one other thing. Probably every member of this committee who is concerned about this issue has talked to medical specialists throughout the country who have been treating veterans who couldn't, frankly, weren't getting help through the Veterans' Administration.

I would request and suggest to you that you either talk to us or the veterans and find some of these people, I could name several of them off now, who have the veterans' trust because they have been responsive to the veterans from the beginning.

And frankly, and I am not promoting the doctor in New Orleans or anybody else like that, but there are some doctors that these veterans feel like they have gotten some help from. I would recommend in the pilot study that you incorporate, build these people in. Not just say they are welcome to come visit with us, but build them into the consultations so that this will pass the smell test, I guess, for the veterans.

Secretary BROWN. We will have someone to contact somebody on your staff.

Mr. BROWDER. Thank you.

Mr. EVANS. Secretary Brown, one last question. You announced that the records of the Persian Gulf Registry would be reviewed to determine if any veterans should be called back for further testing.

Can you tell us how reviews will be conducted and what criteria will be used for reexamination? If my understanding is correct, the reexaminations are supposed to be done in Birmingham. Will the VA pay travel expenses of veterans across the country who may be called back for reexaminations?

Dr. MATHER. We will be looking at the results of Birmingham and also looking at the Registry exams with the kinds of symptoms that we would expect to see. Our hope is that we would not have to bring the veterans into Birmingham, but would be able to reproduce what Birmingham is doing all around the country.

Mr. EVANS. Mr. Secretary.

Secretary BROWN. What about travel pay?

Dr. MATHER. Well, then travel pay wouldn't be an issue, if they were going to their local VA.

Mr. EVANS. If they were going to Birmingham, though, would you look at that issue?

Dr. MATHER. Our hope is—there is no way that probably Birmingham could handle all of these.

Mr. EVANS. But if there are some of them that have to go to Birmingham?

Ms. RITTER. It is our plan at this point to develop a protocol that could be exported to other VA Medical Centers throughout the country, so no one would have to make the long trip here. I mean not here, but to Birmingham.

Secretary BROWN. Yes. But answer this question. Let's just say, for instance, a veteran lives 60 miles from his local VA. Would he have to pay travel expenses?

Ms. RITTER. Unless something happens to change the authority, only people who are service-connected are eligible for travel pay.

Secretary BROWN. Give us a chance to look at that, sir.

Mr. EVANS. We appreciate that.

Thank you very much for your testimony, Mr. Secretary. We appreciate your work as well as the panel's work.

I just want to emphasize to everybody here we appreciate all the veterans of the Persian Gulf War that have been with us all afternoon.

This is a bipartisan issue, as far as I am concerned. We have had good support on the Republican side. We very clearly want to get answers just as quickly as possible, and we appreciate the VA trying to help us in that way.

We will now conclude the hearing.

[Whereupon, at 4:17 p.m., the subcommittee was recessed, to reconvene subject to the call of the chair.]

APPENDIX

Statement Of The Honorable Jack Quinn
Subcommittee On Oversight And Investigations
November 16, 1993

Mr. Chairman, this is my fifth hearing in which we have examined the large number of Gulf War veterans who complain of a "mystery illness" - Gulf War Syndrome.

Some explain it as Multiple Chemical Sensitivity Syndrome (MCSS). Others offer some kind of virus as an explanation. Still others feel it may be the result of a bite of a sand flea.

Regardless, Mr. Chairman, close to three years after the end of the war in the Persian Gulf and after the initial reports of these ailments we still don't know what exactly is causing our veterans to become ill.

Too many of our service men and women are suffering from the same kinds of symptoms - fatigue and muscle and joint pain among them. We must get to the bottom of this.

I am deeply alarmed and outraged by allegations of chemical warfare conducted by Saddam Hussein and the Iraqi forces. Iraq could be responsible for exposing our vets to hazardous chemical agents.

As you are aware, Mr. Chairman, the Department of Defense (DOD) released a statement last Thursday stating that Czechoslovakian chemical defense units detected chemical agents - the nerve agent sarin and the mustard agent yperite - during the first days of the Gulf air campaign.

Although low and explained as "probably the result of allied air strikes against chemical munitions depots in Iraq," these reports raise the possibilities that our forces were exposed to hazardous chemicals.

While DOD maintains that there is little likelihood of a connection between the Czech reports and the unexplained Gulf War illness, it still raises many questions.

Just what happened? Was the presence of these chemical agents a result of Iraqi chemical munitions depots being destroyed by allied air strikes or was it a result of a chemical attack by Iraq? What were the levels of concentration of these chemicals in the atmosphere?

What will be the effect on our veterans in both the short and long run? How can we best monitor these effects and what effective treatments are available?

I commend Secretary Brown for his recent announcement that VA will begin testing Persian Gulf vets for health problems that may be related to their exposure to chemical agents - it is certainly a step in the right direction. We must consider all possibilities.

By collecting medical history and exposure information, I hope we can start putting the pieces of this puzzle together.

I understand that DOD has sent officials to Prague to investigate these reports and I will be sending a letter to Secretary Aspin emphasizing my concerns and the importance of a thorough inquiry.

I believe it is the least we can do for the veterans I have heard testify before this Subcommittee and the Full Committee; for the veterans I have heard from across the United States; and particularly those back in my home district of Buffalo in Western New York.

Congressman Mike Kreidler

Opening Statement
Oversight and Investigations Hearing

November 16, 1993

Mr. Chairman, during Desert Storm I was called to active duty and assigned to an army hospital in Washington State to process troops going to and coming from the Middle East. So I have a deep, personal commitment to the men and women who served. I would like to express to you my gratitude for holding this hearing and for leading the fight on behalf of Persian Gulf veterans.

After our hearing on June 9th and the subsequent passage of H.R. 2535, I felt the VA and DoD were beginning to give the medical problems of Persian Gulf veterans the proper priority and recognition. However, today I no longer feel this way.

During the past month, we learned the Czech military detected possible chemical weapons use during Operation Desert Storm. I cannot express my disappointment with the DoD's response to this information. DoD's continuous denial and recalcitrance on this issue is hauntingly similar to its history with Agent Orange.

The connection between chemical exposure and subsequent illness is not an easy one to prove and is even more difficult when the kinds of chemical levels of exposure aren't readily available. But that doesn't mean we can't or shouldn't try to find it. There are too many cases of veterans with mysterious symptoms to dismiss them. DoD has an obligation to the service men and women to be forthcoming with all its information and it cannot continue to ignore the men and women who defended their country.

While I am dismayed by DoD's actions, I am very pleased by Secretary Brown's initiative to have the Department of Veterans Affairs begin testing Persian Gulf veterans for health problems that may be related to exposure to chemical agents.

I strongly urge the Administration to start a coordinated agency effort to put to rest the questions surrounding chemical weapons use in the Persian Gulf. In the mean time, I hope this committee and the House Armed Services Committee will continue its search for information.

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REP. CORRINE BROWN

VA Subcommittee on Oversight and Investigations
Hearing on Persian Gulf Veterans
November 16, 1993

Statement

Thank you, Chairman Evans for holding this hearing. I want to thank you, Mr. Kennedy and other members of the Committee who have been leading the way on this issue. We need full disclosure and accountability by the Department of Defense on the possible chemical and biological warfare agent detection and exposure in the Persian Gulf and their link to the illnesses exhibited by our Persian Gulf veterans. In addition, I hope that the Department of Veterans Affairs is prepared to answer questions from this Subcommittee about the problems that our Persian Gulf veterans are having in getting medical treatment from the VA system.

Last Friday, I was on a local television show which focused on the problems of Persian Gulf veterans. Two veterans, a man and a woman, told me of their serious health problems which have eluded diagnosis, and the financial hardship that they are under. To them, the worst part of all was that they did their duty and faithfully served their country in the Persian Gulf; and now they are engaged in a new battle with the DoD and VA to get the recognition and medical treatment that they deserve.

To Persian Gulf veterans around the country, I want to assure you that your voices are being heard and that Congress will continue to fight to get to the bottom of this tragic situation. The Veterans Affairs Committee has undertaken an aggressive agenda to address the concerns of the brave men and women who served in the Persian Gulf, and we will continue to do so. Thank you, Mr. Chairman.

Statement by Rep. Mac Collins (GA-3)

Mr. Chairman,

I appreciate the opportunity to participate in this hearing today. A number of veterans from my district have been suffering from illnesses they believe to be connected to their service in the Persian Gulf, and quite frankly their battle for health care at home has been more difficult than winning Desert Storm.

Back on August 12, I first met with members of the 24th Naval Reserve Construction Battallion based in Columbus, Georgia. My goal from the first time I spoke with them was to see that they received the quality health care that they need and deserve. Dr. Charles Jackson from the Tuskegee Veterans Medical Center has tested these men, and I look forward to discussing this with him this morning. The reports on the illnesses of these CBs are confusing to them and us, and I hope today to get to the bottom of some of those questions. Dr. Jackson has tested a number of them for HTLV I&II a virus which causes cancer, and could be caused by biological weapons. Three were told that they tested positive, four have been tentatively diagnosed with lymphademopathy or early stages of lymphoma, and one has full blown lymphoma cancer. Also the CBs heard that eleven of them who were tested for HTLV I&II tested positive and could develop lymphoma cancer. They were never given the results of their tests. We must get to the bottom of the diagnosis of these troops. They are suffering and their families are suffering. Enough is enough.

Since that first meeting, I have had corresponded to and had meetings with representatives from the Office of the Secretary of Defense, Joint Chiefs, Navy, Army, Defense Intelligence and Reserve Commands. I later met with Major General Blanck, and want to publicly thank him for his candor and willingness to work on behalf of the members of the detachment. I have also met with Dr. Susan Mather, Dr. Roswell of the Birmingham Veterans Medical Center and Mr. Jimmie Clay of the Tuskegee Veterans Medical Center. I have corresponded with Secretary Brown and various DOD Undersecretaries as well. I believe the new program at

Birmingham VA Medical Center is a step in the right direction.

On January 20, 1991 the members of the 24th Naval Reserve Construction Battallion, Detachment 1624 were based in Al-Jubayl, Saudi Arabia. On that evening their unit came under what they believed to be a missile attack. They heard explosions which I understand that the military is now calling sonic booms. They immediately went to MOPP level 4, indicating the strong possibility of a chemical attack. Within two hours after being notified that all was clear the military collected all their gear. Shortly after this incident a number of the CBs began to feel numbness around the lips and burning sensations. They believe they were hit with a chemical attack. I pursued this question in meetings with DOD and am told that there was no chemical attack.

My first concern is getting health care to these men immediately. If there was a chemical or biological attack we should know that and do what is necessary to provide these men with health care. If there was not such an attack we should seek to discover what is causing their illnesses, whether it be multiple chemical sensitivities or other. But the bottom line is that they need answers, and they need health care now.

The health of these men is deteriorating. This is not a philosophical debate about the role of the Department of Defense or the Veterans Administration. It is a life and death struggle for these men and their families. Someone must take responsibility for these Gulf War Veterans.

At my request, Major General Blanck has worked with the Navy to have a team to go down to Columbus December 4 and 5. Last week, I received a letter from Undersecretary of Defense Edward Martin that said they would include someone from VA on that team. I also understand this team plans to go to Al-Jubayl, Saudi Arabia to conduct testing there.

I have a number of statements from members of this unit that I would like to have inserted into the record. I thank the members of this committee for their

diligence and dedication to getting to the bottom of this crisis. Let me close with a note from Kristin Westbrook, the granddaughter of Chief Petty Officer Roy Butler from detachment 1624. "Hi my name is Kristin, I am 11 years old. Why won't our government help my grandpa? My mama says you are trying to help him, so are alot of other people. Thank you very much... She goes on to ask that we tell President Clinton about the sick veterans. She closes with: "Tell him to hurry, because I don't think my Poppa has much time left. I love him very much and I don't want to lose him."

Thank you Mr. Chairman.

Congressman Mac Collins
1118 Longworth HOB
Washington, D.C.

Dear Congressman Collins,
We are the grandchildern of Chief Petty Officer Roy W. Butler Naval Mobile Construction Battalion 24 Detachment 1624 from Columbus, Georgia. We are very concern about our Poppa. He is very sick since his service in the Persian Gulf War. He gets worse every day. We are asking you to please help him.We love our Poppa very much, we don't want him to die The doctors at the V.A. will not help him ,they will not even give him anything for pain. Our Poppa hurts everyday. It is very hard for him to go to work everyday. Please hurry! We don't know how much longer he will be able to work. Please, Please help get our Poppa his disability started.

Hi, my name is Courtney. I am 8 years old. Please, help my Poppa get better.I love him very much.

HI my name is Micheel Ryan. I am 4 years old. Please help my Poppa. I don't want him to die cause I love him and he loves me.

Hi my name is Stephanie. I am 18 years old. If our country can't treat our Veterans any better than the Gulf War Vets are being treated then maybe everyone should be like President Clinton and stay out of the service. I think it is really awful that we can spend more money trying to feed the Somalians than we can to help our Gulf War Vets.Please help my Poppa. I love him very much.

HI my name is Kristin. I am 11 years old. Why won't our government help my grandpa? My mama says you are trying to help him, so are alot of other people. Thank you very much. It means so much to all of us. Please ask President Clinton why he never says anything on T.V. about our Seabees, doesn't he care? Please tell him to help all of the sick Vets. Tell him to hurry because I don't think my Poppa has much time left. I love him very much and I don't want to lose him.

Hi my name is Scott. I am 8 years. My Poppa and I go deer hunting and four-wheeling together,but he is sick now and we don't get to do as much anymore. Please help my Poppa he is a good man. He loves all of us very much. He doesn't laugh and smile as much as he used to. I miss my old Poppa please help me get him back. I pray for him every night. I ask Jesus to make him well again. Please help my Poppa if you can

Hi, my name is Bryan . I am 17 years old. Thank you for all the help you are giving all of us. Tell everyone else who is helping that we appreciate their help as well. I often thought of joining the service to serve my country like my Poppa has, but if I am going to be treated like he has I think I will find another way to serve my country.I am proud to be an American,but right now I am ashamed of my government.I wish the Pentagon would admit the truth about what happened in the Gulf. My Poppa tells me what happened,he doesn't lie, but the Pentagon continues to say he is.I am asking you to keep working for us until they tell the truth, so many lives are at stake. Without people like you we would have no hope. Make me proud of my government again.

Hi my name is Dave. I am 15 years old. Why does everyone act like Saddam would not use chemical or biological warfare on our people when he used it on his own people? I think Saddam is just like Hitler.Why does our world let him get away with all the things he does?But I guess he is right this is "The Mother of all Wars". If the Pentagon continues to deny chemical

weapons were used what about biological warfare? That's what Poppa said Dr. Jackson said was wrong with him . He diagnoised him with H.T.L.V.1and 2. He said it works like A.I.D.S. but its not A.I.D.S. it is caused by germ warfare. Why won't anyone talk about this?If this is true my Mimi could die too! So could alot of other people, what if it is in our blood supply? Saddam could kill us all!Please work to bring out the truth.Help Dr.Jackson to continue to help all of our Vets sometimes I think he is the only doctor in the V.A. that cares. Thank you for all your help,we will never forget you and all you have done for our family.

Courtney Gibson

Scott Gibson

Stephanie Gibson

Kristin Westbrook

Michael Ryan Jarvis

Bryan Westbrook

Dave Westbrook

11-11-93

Roy W. Butler
5807 Webb Ave.
Columbus, Georgia 31909

November 14,1993

Congressman Mac Collins
1118 Longworth HBO
Washington, D.C. 20515

Dear Congressman Collins,

My name is Roy W.Butler petty officer first class. I served with Naval Mobile Construction Battalion24 at King Abdual Aziz Stadium, with the first and second M.Y.T.H which is located south of Al Jubayl , Saudia Arabia. I served my country proudly for 24 years. I am also a Vietnam veteran.

On January 20,1991 about 03:00 our compound was awaken by two large explosions. Everyone put on their gas mask and went to the bunkers. We stayed in the bunkers until the all clear was given. After the all clear, several of us were standing around the latrine waiting our turn. When the sky above us lit up.

Shortly after the hand crank siren on the watchtower behind us sounded. A marine on the handcrank started yelling "chemical attack, chemical attack"mark level 4. By the time I don my mask all of my exposed skin was burning like I was on fire.I had to remove my mask to clear my nasal passages as I could not breath.My lips turned numb. As I learned in training this was a symptom of nerve gas so I immediately put on my chamical suit. There was a message from the port that the British chemical detectors had detected mustard gas. A short time later the front gate called for decontamination teams to come to the gate and decontaminate six passsengers and a vehicle. Both messages come across our radio frequency. It was shortly after the events of this night I began to,have problems.

I suffer from hair loss, memory loss, stiffness and joint pains which continues to worsen daily, I also have deformed toenails, headaches and have lost an inch and a half in height. My health is rapidly deteriorating .I can't continue to work much longer. I have a very difficult time getting out of bed as I am so stiff and in much pain.

On July26,1993 Dr. Jackson of the V.A. hospital in Tuskegee Alabama diagnosed me with H.T.L.V. 1and 2 Category.He as diagnosed Roy Morrow with the same thing. Dr.Jackson talked to us for several hours explaining his diagnosis. He told both of us it was a man-made virus that destroys the immune system allowing cancer to set in. He told us that it was very contagious,not to have unprotected sex, give blood, or allow anyone to eat or drink after us. I told him "we've been home for two and half years don't you think its a little too late to be telling us this now."Everything Dr. Jackson said would happen to us is happening.It is falling in place just as he said it would. Someone in Washington has got to listen to this man,.The consequences of what he is saying are far reaching and devastating. Gulf War Veterans are sick and dying.Most are dying from cancer just as Jackson said we would. He says there is no cure.This virus is probably in our country's blood supply. It might be too late for me, but I can try to save someone else. The truth has to come out. I know our government they will never allow it to happen though. I am asking you to please help me get my disability started as soon as possible. I have a family to support and bills to pay. I am trying as hard as I can. but I can't last much longer

I don't want to leave my wife without anything to take care of her. If what Dr. Jackson says is true my wife will end up being sick as well. Please we need help NOW!

I want to thank you and so many others for all your help. We have no one else to turn to. Our government has turned their back on us. We were good enough to go to war for our country,but they don't think we are good enough to save or help We are yesterday's garbage to them they have thrown us in the gutter to die.Please get us out of the gutter. We are important and worth the trouble.We gave all we had.

Roy Butler

Phyllis S. Butler
5807 Webb Ave.
Columbus, Georgia 31909

November 12,1993

Congressman Mac Collins
1118 Longworth HOB
Washington D.C. 20515

Dear Congressman Collins,

I am writing on behalf of my husband Roy W. Butler. Roy was diagnosed by Dr.Jackson at the V.A. Hospital in Tuskegee, Ala as having the viruses of the H T L V. 1and 2 category

It was the 26 of July 1993 that Dr.Jackson talked to my husband and Roy Morrow who also served in the Gulf War. He talked to them for several hours explaining his diagnosis, his research on this and what they could expect to happen to their health. Attached is a copy of what was writtten down that night while he was talking to them.

I can't explain or begin to explain what this diagnosis has done to both men. Their whole world has been turn upside down. Dr.Jackson said he believed they were exposed to Biological and Chemical Warfare.

August 13,1993, my husband had an appointment at the V.A. not related to Dr.Jackson, but by chance we got to talk to him. He said the Navy and Washington had been calling and they were very angry with him and he refused to discuss Roy's diagnosis with me. He was rude to me and in return I was rude to him. I gathered he had been told to shut-up, the familiar two words told to the Gulf Veterans about the chemical attack they experienced January20,1993. Finally Dr.Jackson explained Roy's diagnoeis to me and what to expect after I demanded I had a right to ask questions.

After Dr. Jackson dropped the bomb on my husband and Roy Morrow telling them it's contagious, could give this to their families, they would end up with cancer, would have to be monitored the rest of their lives and so forth he never said I want to see you in two weeks or one month or nothing- he just dropped them with no follow-up.

My husband served his country in Viet Nam and in the Gulf War Is this what he deserves for that?Roy needs medical care , everyday is precious-time is not on their side.He has swollen lymph nodes in groin area, joint aches, constant pain, memory loss just to name part of what he is going through.

I know now or I believe Dr. Jackson gave Roy Butler and Roy Morrow his test results on them hoping to bring this out in the open.I do know this man is the only V.A. doctor trying to help our Veterans but some one tried to silence him.

Defense Secretary Les Aspin ruined his image with the American people over his handling of Somalia, I hope he realizes his denial and possible cover-up could finish him off He's in no postion to make another mistake.

Congressman Collins, I want totake time now to express my graditude for all your help and support and believing in our Gulf Veterans. Your have devoted a lot of time to them and this will not be forgotten. You have proven you are a very caring man.

Sincerely,

Phyllis S Butler

Dana Westbrook
8 Layfield Dr.
Phenix City, Alabama 36869
205-291-0019

November 14,1993

Congressman Mac Collins
1118 Longworth HOB
Washington,D.C.20515

Dear Congressman Collins,

I am the daughter of Roy W Butler,Chief Petty Officer 1 class My dad was a member of Naval Mobile Construction Battalion 24 detachment 1624 of Columbus, Georgia. I am writing today on his behalf and all of his fellow veterans.I have many concerns regarding this situation.

My dad like many other vets, is suffering from many different symtoms such as swollen lymph nodes, memory loss which continues to worsen rapidly, joint aches, hair loss, headaches, and constant pain. My dad like many other vets is finding it increasing harder everyday to work. He has starting keeping a notebook to help him remember things, but loses his notebook he can't remember where he puts it. The lymph nodes in his groin area are so swollen it is painful for him to walk.

Like you I wonder why our goverment will not come clean on this issue. What do they have to hide? Who are they protecting? Are they guilty of illegal activites? Did someone in our government sell Saddam the technology or products he need to create his chemical and biological stock pile? Did he then turn around and use this on our people or perhaps we blew it down on our selfs from the bombing?At any rate I want answers to the puzzle. The problem has recked havoc not only on my family but thousands of others as well.We all live with these and many other questions everyday. We don't know what the future holds for us. I am sure this will be the last Christmas for many of our veterans. It is hard to face the Christmas season with such thoughts.My dad is too young to die but vets younger than him have already died.Where will all of this end?

If what Dr. Jackson told my dad is true I will probably bury my mother as well. Do I deserve to lose both of my parents because my dad served his country?Dr. Jackson told my dad and mom both that the virus that he diagnosised him with is contagious. How many Americans have to become sick or die before our government wakes up?Doesn't anyone realizes if what Dr. Jackson is saying is true this virus is more than likly already in our country's blood supply? It will continue to spread unchecked. We will be facing a new A.I.D.S. epidemic, are we ready for that? I don't think so. So many are trying to shoot down Dr. Jackson's diagnosis but my gut feeling tells me he is right on the money. I believe thats why they tried so hard to shut him up. I hope more than anything in the world he is wrong I stand to lose too much if he is right. I pray for answers and a miracle everyday. This is a heavy burden to carry.

I am asking you to help my dad get his disability pushed through faster if possible. My parents are facing possible death they should not have to worry about losing everything they worked for all their lives. My dad needs immediate medical attention. He doesn't need to hear it's all in his head anymore.It's difficult to work while you are in constant pain. A sick man can only go for so long.

As Saddam said this is The Mother of all Wars, we have to fight our own government. A government that is suppose to be there to serve us. Les Aspin, the Joint Chiefs, V.A. and President Clinton just to name a few would do well to remember that in a democracy the supreme power is retain by the people. If they want a fight they have one. The American people will only put up with their garbage for so long and when they had enough all hell will break loose. If they value the jobs they had better get busy and do what the taxpayers of this country are paying them to do . I've already had all I intend to take. I will fight with all I am and all I have to see justice for our veterans and their families.

Congressman Collins just knowing you and so many others are on our side makes this situation more bearable. We appreciate all your help, concern, compassion and honesty. You have proven your integrity to all of us. Let me also say Mrs. Gillispie is one in a million, she is never too busy to talk to us when we call . She answers our questions and has comforted me many times when I cried.May God bless all of you and guide us to the answers we seek.

Sincerely,

Dana Whitbrook

Doctor's statement

Dr. Jackson, from the V.A Hospital Tuskegee Alabama told me that I have tested postive H.T.L.V.-I II Western Blot Asketeminant R.&.P21. This is a very rare virus. It is a Virus that Causes Cancer. It is a man made virus. This virus Can Cause Lymphonia, Leukemia, Brain Tumors, Kidney failure, Thyroid Cancer. This virus has something to do with the Humon T-Cells.

Dr. Jackson said this will be some thing I will have as long as I live. This will have to be Closely monitored the rest of my life. Dr. Jackson said it attacks the lymph nodes the same as Aids, But not Aids. He also told me that I could not be a blood or organ donor. He said the virus was highly Cotoyious.

I am very concerned of my family. I don't know if I have give them the virus or not. He said the Virus Could be passed through sexual Contact. My wife and I have been having unprotected sex since I

have returned from Saudi Arabia over two years now. Dr. Jackson said they were no cure for this virus. I will die with it.

I don't know how much longer that I can work. I am getting weaker ever day now. Please sir! I need some help! For I am a hourly worker and don't have money to take care of my family if I can't work. I know I will not be able to work much longer.

I am absolute positive that I get this virus while serving in Saudi Arabia in Desert Storm.

Sincerely,
Ray W. Butler,
257-64-9338

5807 Webb ave
Columbus, GA
31909
Home #706 563-3095
Wk. #706 [redacted] 544-9331

AFFIDAVIT, POWER OF ATTORNEY AND RELEASE
FOR MEDICAL RECORDS

My name is Nicholas Eugene Roberts. I have been examined and treated at the Veteran's Administration Hospital, Tuskegee, Alabama, for injuries and diseases resulting from combat duty in Saudi Arabia during the years 1990-1991 as a member of N.M.C.B. 24. I desire and request of the Veteran's Administration Hospital that a copy of all medical records of all tests performed, clinical examinations and evaluations, laboratory testing and data, history and physical notes, examinations, treatments, evaluations, doctors' impressions and diagnoses; all correspondence between the environmentalist physician, C. Jackson, M.D., and any and all Veteran's Administration, Navy Department, Army Department, and Walter Reed Hospital personnel; all records or schedules demonstrating scheduled examinations (including blood gathering) to be performed on August 21, 1993, and/or August 28, 1993, at the Naval Training Center, Columbus, Georgia; all correspondence between any physician or administrative personnel of the Veteran's Administration Hospital in Tuskegee, Alabama, and any other party including the Veteran's Administration, Washington, D.C., United States Navy Department, Washington, D.C., Commanding General Ronald Blanck, Walter Reed Army Medical Center, Washington, D.C., United States Public Health Service or any of its subsidiaries concerning me or any other member of my Naval Reserve Unit N.M.C.B. 24; all records at Veteran's Administration Hospital, Tuskegee, Alabama, of my being afflicted with Lymphadenopathy, Lymphoma, Hepatitis A and Hepatitis B, immunity problems manifested with serum

immunoelectrophoresis, and viruses of the HTLV-I/II categories; all correspondence canceling blood gathering from me scheduled for August 21, 1993, and/or August 28, 1993, at the Naval Training Center, Columbus, Georgia; all records of Dr. Rollins, all records of Dr. Rebea, and all records from Bureau of Medicine (BuMed) of the United States Navy having reference to any treatment or examination or disease for which I was examined or diagnosed while at the Veteran's Administration Hospital in Tuskegee, Alabama, be provided to my attorney, Frank O. Burge, Jr., 2300 SouthTrust Tower, Birmingham, Alabama 35203, and, by these presents, I do hereby authorize and appoint him my duly attorney in fact to receive these records from the Veteran's Administration Hospital, Tuskegee, Alabama.

Done at Birmingham, Alabama, this the 16 day of September, 1993.

Nicholas Eugene Roberts
NICHOLAS EUGENE ROBERTS

STATE OF ALABAMA)
JEFFERSON COUNTY)

Before me the undersigned authority in and for said County and State, personally appeared NICHOLAS EUGENE ROBERTS, who is known to me and who after being by me first duly sworn, states that the facts set forth in the foregoing Affidavit are true and correct.

This 16 day of September, 1993.

Nicholas Eugene Roberts
NICHOLAS EUGENE ROBERTS

Sworn to and Subscribed
before me this the 16
day of September, 1993.

Jane H. Blalock
NOTARY PUBLIC
MY COMMISSION EXPIRES: 5-17-94

STATE OF GEORGIA

COUNTY OF MERIWETHER

AFFIDAVIT

Personally appeared before the undersigned officer, duly authorized to administer oaths, THOMAS L. HARPER, COMMUNICATIONS CHIEF FOR MMCR 24'S AIR DET., who says under oath the following:

"At approximately 3:30 AM January or February, 1990, two ground shaking blast occurred in our area.

I had left the Command Post Bunker earlier to get a few hours sleep. SU2 Linder was manning the radios at the time of the blast.

It wasn't but just a few minutes after I got back to the CP that the "All Clear" was sounded.

Linder and I called the bunkers and the "holes" relaying the "All Clear" message we had received.

Shortly after this, a message came down to the stations on our covered net, "ALPHA 6 BRAVO, ALPHA 6 BRAVO, We have a confirmed chemical agent."

Our camp net, broadcast a message to all stations, "Mop Level 4, Mop Level 4, All Stations, This is not a drill"

At that time I relayed the messages to our people.

Some more of our people fell into the CP at this point saying a fine mist had fallen over the camp and others were complaining of numbness in their lips and fingers. One man even pulled off his mask complaining about not being able to breath. Everything was really hectic at this point.

One of the radios sent down a message asking for the Decon Teams. Another individual radioed asking "What to do."

RAOC was sending "Down Wind Messages"

I was trying to put on my mop gear, take messages and try to keep from panicking.

My memory is not real clear on everything, but I do remember later that morning a marine and our CBR man came to the bunker and said to me, "Not a fucking thing happened last night is that clear, no Mig bombed us and its not laying belly up in the Gulf - No Decon Teams, Not a fucking thing happened."

I have been telling doctors for two years this is what happened to us over there. They do not want to hear it. One said I have Post Traumatic Stress Syndrome. The doctor at the VA said "I don't know what's wrong with you guys."

All I know is what happened to us."

FURTHER affiant sayeth not.

Thomas L. Harper

THOMAS L. HARPER - AFFIANT

SWORN TO AND SUBSCRIBED BEFORE ME

THIS 7th DAY OF JUNE, 1993.

Cindy D. Armstrong

NOTARY PUBLIC (SEAL)

November 14, 1993

Dear Sir:

In my affidavit, June 7, 1993 I neglected to name our CBR man. His name is BU2 Harold Edwards.

Thank you,

Thomas L. Harper

Thomas L. Harper
256-11-8184
P. O. Box 233
Shiloh, Georgia 31826
706-846-3224

November, 14, 1993

Dear Sir:

My name is Thomas Lewis Harper. I was a member of NMCB-24's Air Det. stationed at King Abdul Aziz Naval Base, Al Jubal, Saudia Arabia during Operation Desert Shield/Desert Storm. Since returning home I have been sick and believe it was from being exposed to chemical and biological weapons used by Iraq during the war. My symptoms are aching joints, heartburn, memory loss, shortness of breath, fatigue, rashes, dizzy spells, diarrhea, swollen lymph nodes,and headaches.

Before I was deployed to Saudia Arabia I was in good health. After our return, I told our Medical Department repeatedly that I was sick and believed it was from being exposed to Chemical Weapons used by Iraq during the war. I was told by the Medical Department they were going to send everyone that was having problems to Bethesda Naval Hospital to get help. I was told to put my name on the list to go.

The Navy put me on the Physical Readiness Training Program (Fat Boy's Club) on July 18, 1992. My body fat percentage was getting too high for Navy standards.

On September 12, 1992 I went for a physical at Fort Benning and I told the doctor of my symptoms. He asked if I could do the Physical Readiness Test and I told him no. He didn't even ask why, he just said "Okay, no P.T."

In November 1992 a team of doctors from Bethesda Naval Hospital came to the Reserve Center. I told the doctors of my symptoms and they said I might have arthritis, and that it was all in my head. They also told me I have Post Traumatic War Stress Syndrome.

Also in November 1992 I got on the Desert Storm Register. They made me an appointment for February, 1993.

In December 1992 I went to my family doctor because my health was getting worse. He prescribed medications to help me get by until my appointment at the VA Hospital in February.

February 1993 I took the Desert Storm physical and they drew blood for lab work at the V.A. Hospital in Tuskegee and saw the doctor. The doctor asked if I was having any problems. I told him of my symptoms and he sent me to the lab for more blood work. I received no treatment for any of my problems.

In March 1993 I was put out of the Reserves for failing to meet the Navy's Physical readiness Standards. I was told it would be an administrative discharge. I asked the Corman why it wasn't a medical discharge and he showed me my medical records. There was a statement incloseed by some doctor I have never seen saying something about failure to show progress and that I had been counciled. There was nothing in my records about my many complaints of being sick or what the doctors for Bethesda told me. I was advised by the Corman to take the discharge and not stir up any trouble. As of today I still have not received my DD-214.

On April 16, 1993 I was called back for more blood tests. I didn't even see a doctor at this time.

July 29, 1993 Dr. Jackson had me come to the VA Hospital for another blood test, the HTLV 1 & 2. I saw Dr. Jackson on this visit and told him my joints, memory loss and fatigue were getting real bad. He found my lymph nodes were swollen and set me up for an appointment to have a biopsy done. He also gave me medications for my joints, heartburn, and something to help me sleep. This is the first time I actually got any kind of treatment.

August 2, 1993 when I went for the biopsy the surgeon told me he didn't see any sense in giving me a "free cut" so Dr. Jackson could do his little test. He said they were not swollen bad and the last two people he did didn't show anything. I went home, a wasted day, no biopsy, no treatment, no nothing.

On August 4, 1993 the rash was on my neck, shoulders and arms real bad. I went to my family doctor August 5th, he said he had never seen a rash like this before but he prescribed some medication hoping it would help. The rash just got worse. I had to leave work on August 9th to go to the VA Hospital hoping they would help me. Dr. Jackson admitted me that night, said he had not seen the rash that bad on any of the Gulf Vets and told me while I was there he would get the biopsy done. I was put under Dr. Rollins care on August 10 but didn't see him until 3:30 P.M. He gave me a physical and asked alot of questions about my problems. On August 11th, Dr. Rollins examined my lymph nodes and said they were not significantly swollen to have a biopsy. On the same day Dr. Jackson told me if Dr. Rollins wouldn't schedule a biopsy to go to the Chief of Staff. August 12th, Dr. Rollins said he and Dr. Jackson agreed there was no need at this time to have a biopsy done. I was in the hospital for a week for "contact dermatitis:?, and received no treatment except being given Prednisone Vistaril for itching.

With Dr. Jackson stressing I needed to have a biopsy and Dr. Rollins stressing not to worry about it I decided to go to a private doctor.

On August 18, 1993 I went to Dr. Chipman in Columbus, Georgia. He examined me and said my lymph nodes were swollen and scheduled me for a CT Scan. I went back for the results on August 27, the diagnosis was lymphadenopathy. He told me to come back in November for another CT Scan so he could see if there was any change.

October 5, 1993 I went to the VA Hospital for a follow up visit with Dr. Rollins. He asked if I was having any problems. I told him about seeing Dr. Chipman and the diagnosis. He then examined me and said my lymph nodes were swollen and wanted to do his own CT Scan. I don't understand why Dr. Rollins waited until now to admit my lymph nodes were swollen enough to do a CT Scan when he wouldn't do it while I was in the hospital and Dr. Jackson was saying they definitely needed to be checked out. It was only two weeks between the time Dr. Rollins said "Don't worry about your lymph nodes" and I was diagnosed by Dr. Chipman with lymphadenopathy. Dr. Rollins also set me up for upper GI Series and for an HIV test.

On October 20, 1993 I went to the VA Hospital for a CT Scan. I ran into Dr. Jackson and he told me he was going to call everyone back for more tests. He now believed it was a biological agent we were exposed to, possibly the same as Russia used on Afganistan. He also looked at the results of my HIV test, it was negative. One less thing they can blame it on!

November 4,1993 I went to the VA for the Upper GI Series. I asked the x-ray technician why Dr. Rollins would want the GI done. He looked in my records and said the doctor had put in them that I have a history of ulcers. I don't have a history of ulcers! That was the first GI I have ever had, I didn't have stomach problems before the war. I also saw Dr. Jackson and he got my CT Scan results and told me it was suggestive pancreatitis. He asked if I drink alcohol and I told him I am a non-drinker. He said they usually see this in excessive drinkers.

On November 10, 1993 I went back to see Dr. Chipman as told to. He examined my lymph nodes and said there was no change, they were still swollen but before doing another CT Scan he wanted to do some blood tests. Dr. Chipman requested all results from all tests the VA Hospital had done and all he received was some of the results of the earliest tests done. They sent nothing to help him treat me. Dr. Chipman decided to do his own blood test consisting of the executive profile, hepatitis comprehensive profile and the HTLV 1 & 2. He also prescribed an antibiotic (Diflucan 200 mg) after I told him that Dr. Jackson beleives it was a biological agent I was exposed to during the war. He hoped the antibiotic would kill any fungus caused by the agent. So far Dr. Chipman has diagnosed me with anxiety, fatigue and lymphadenopathy.

Every time I go to the VA Hospital the first thing I am asked is "Are you service-connected?" When I tell them no they tell me to have a seat and I wait for hours to be called. If you are service-connected you have precedence over everyone else. How do I get service related when the doctors at the VA Hospital keep giving me the run around? They keep suggesting or questioning if my problems could be caused from my civilian job, if I am gay, a drug abuser, if I have arthritiis or if I am involved in "hanky-panky". With all the blood tests done by this time they should be able to rule all these possibilities out and make some type of diagnosis.

All I want to know is what I was exposed to in the Gulf so I can get the proper medical treatment I need without all the run around. I miss work having to sit all day at the VA Hospital even

though I have morning appointments. When I don't work I don't get paid. Having to go to private doctors because of the run a round from the VA Hospital doctors and being in the hospital for a week is causing me and my family financial problems. It has also put a lot of stress on me and my family.

I filed a claim with the DAV in November 1992 but they can't help me without a diagnosis.

I fought for my country and now that I may be fighting for my life it seems my country has turned its back on me. It took the Viet Nam Vets almost 20 years to get help for Agent Orange, is it going to take us that long? The Gulf War Vets are dying now.

Please we need your help now, not twenty years from now.

Thank you,

Thomas L. Harper

Thomas L. Harper
256-11-8184
P. O. Box 233
Shiloh, Georgia 31826
706-846-3224

19 September 1993

ELVIS R. RICH 444-40-8158
USN Reserve (Retired 1Sep92)

Problems since returning from Persian Gulf, Operation Desert Storm-Desert Shield:

(1) Had sinus and ear blockage starting while in Saudi Arabia. Seen at Columbus Emergency Medical Center, Whitesville Rd, Columbus, GA, Sep 92. Treated for acute skin infection with ractive lymphadenopathy. (Columbus Emergency Medical Ctr 322-2223)

(2)Prostate enlargement found on USN discharge physical from active duty back to reserve status. Work-up started at Martin Army Hospital until benefits ran out. I went to civilian physician where prostate biopsy was done. Pathology report revealed "focal atypia". Continuing follow-up.

(3) Chronic epigastric distress (swelling, bloating, exacerbated by eating). Medically diagnosed with gastritis and duodenitis. Gastric biopsy revealed: Acute fungal inflammation consistent with candidiasis of esophagus. Focal acute and chronic inflammation of stomach. Problems persist to date with little relief from medications. Presently taking ZANTAC x2 daily; CHLORD/CLIND daily x4.

PHYSICIANS: Dr. Jeff S. Zabel PH: 322-1066
Dr. William R. LaHouse PH: 322-7884
Dr. W. M. Harper PH: 322-0631

ELVIS R. RICH 444-40-8158

29 October 1993

TO WHOM IT MAY CONCERN:

I, Elvis R. Rich, USNR (retired 1Sep92), submit that since returning from the Persian Gulf, Operation Desert Storm-Desert Shield have had the following medical problems:

1) had sinus and ear blockage starting while in Saudi Arabia. Seen at Columbus Emergency Medical Center, Whitesville Rd, Columbus, GA Sep 92. Treated for acute skin infection with reactive lymphadenopathy.

2) have had prostate enlargement found on USN discharge physical from active duty back to reserve status. Work-up started at Martin Army Hospital until benefits ran out. I went to civilian physician where prostate biopsy was done. Pathology report revealed "focal atypia". Continuing follow up.

3) Chronic epigastric distress (swelling, bloating, exacerbated by eating). Medically diagnosed with gastritis and duodenitis. Gastric biopsy revealed: Acute fungal inflammation consistent with candidiasis of esophagus. My physician is baffled by this, since he says this is something seen in persons with impaired immune systems. This problem continues to date with little or no relief from medications.

4) had crampy lower abdominal pain with passage of blood and mucus in stools. Biopsy of colon revealed two sigmoid polyps one diagnosed as benign villotubular adenoma; the other was "hyperplastic" polyp.

4) presently undergoing work-up (CT chest and abdomen) for axillary lymphadenopathy.

5) further, I suffer periodic skin eruptions, chronic fatigue, hair loss, as well as memory loss - all of which I attribute to exposure to chemical or biological warfare exposure while stationed in the Gulf.

None of the above medical problems existed prior to my duty in the Gulf.

Respectfully,

Elvis R. Rich

Elvis R. Rich
4715 Langdon Street
Columbus, Georgia 31907

14 November 1993

TO WHOM IT MAY CONCERN:

If, as DOD has recently concluded, there was no evidence of chemical or biological warfare agents used by the Iraqis during the Gulf war I would like an explanation for the dead sheep I personally observed while traveling from camp to camp between the Saudi Arabian towns of Re's al Mish'ah and Al Jubayl. I would like a reasonable explanation for the causes of the many illnesses plaguing myself and other members of my unit as well as other service members returning from the Gulf war area.

I personally have gone from a healthly fit individual who rarely needed a physician to one plagued with constant abdominal pain, memory loss, hair loss, prostate problems, skin rashes and enlarged lymph nodes. My health has continued to deteriorate since returning from Saudi Arabia. There has to be some explanation for these maladies suffered by so many of us veterans of the Gulf, other than "post traumatic stress". So far, none has been forthcoming.

I sincerely hope that someone in the government will care enough to seek the cause and at least try to help those of us veterans who are out here sick and perhaps dying without a reasonable explanation for why this is happening.

Respectfully,

ELVIS R. RICH
444-40-8158

BUMED Team Visit Nov. '92

I Roy W Morrow Jr, do here by swear that in Nov of 1992 that a team of Doctors came from the Bethesda Naval Hospital to the Columbus, Georgia Naval Reserve Center to review our complaints of problems from returning from Desert Storm.

The medical team told us there was no reports of Chemical and Biological Warfare. They talk with each of us and told us that our problem was stress. The syptoms that that we were having, that stress would cause all of the syptoms.

We all listen, but we Knew that the syptoms that we were having there is Know way stress could cause these problems.

The Medical Team Review our Medical records with us, but as the Medical Team left and returned to Bethesda some of our records of complaints were missing.

I have proff that the Medical Team purge our Medical records. I have regaind some of my records, but not all of them. I am willing to come forward and show what I have regained and show some of the records of other members of NMCRC 24, that were pulled out of their records.

Roy W. Morrow Jr.

JAN. 20, 91 - SWORN STATEMENT

I, Roy W Morrow Jr, do here by Swear that on January 20, 1991 there were two explosions around 3:00 or 3:30 in the morning. The alarm did not go off we all went to the bunkers and put on our gas masks. Then thirty minutes later, given the all clear signal, we all went out and the Marines were running all around and screaming map level four, map level four gas in the area. We went back to the bunkers. We all went to map level four.

I and several others had burning sensations on the arms, neck, ears and head. Many of us also experienced numbness of the lips while in the bunkers, we all heard confirmed gas in the area, over the radio. We also heard that several personnel and Vehicles at the Main Gate needed to be de-con.

At this time our command called for all de-con teams. They went to the main Gate and help in the de con.

The afternoon of January 20, 1991 our command took up all of our map level four gears and gave us all map level four gear. We were then we were hit with something that morning, but our command told us false alarm, nothing happen, they also told us sonic Boom, but we did not Buy that all and still don't Buy that at all.

We were latter told to stop the told nothing happen. We were order to stop talking.

Roy W. Morrow Jr.

To Whom it May Concern

I, Roy Morrow, do here by swear that on January 20, 1991 there were 2 explosions around 3:00 or 3:30 in the morning. The alarm did not go off. We all went to the bunker and put on our gas masks. Then 30 minutes later, given the all clear signal, we all went out and the Marines were running all around. The marines began screaming - Mop Level 4, Mop Level 4, gas in the area. We went back to the bunkers. We went To Mop Level 4. I and several others had burning sensations on the arms, neck, ears and head. Many of us also experienced numbness of the lips, which lasted for a week and a half.

While in the bunker, we all heard confirmed gas in the area, over the radio, we also heard that several personnel and Vehicles needed to be decontaminated at the main gate. At this time our command called for all decon teams. The next day, we all were told no personnel and Vehicles were decon. It did not happen. We also were told not to discussed it anymore, stop the talk.

Roy W Morrow Jr

I am Roy W Morrow Jr, I was a Second class Builder (ES) with NMCB-24 Sea Bee Battalion in Desert Storm, I was stationed at King Abdul Azizes Stadium in Al-Jubail, assigned to the First Myth Marines.

Since returning home I have been having problems with diarrhea, weight loss, aching joints, Swollen lymph nodes, bleeding gums, Memory loss, night sweats, headaches and fatigue.

I brought these problems to my commands attention here in Columbus Georgia, Naval Reserve Center in may of 1991. The Reserve Center first acted as if they were concern, but after about four months it just die out.

I needed help from (DAV) they got myself and three other people a appointment with Tuskegee VA Hospital in Tuskegee Alabama in Sept. of 1992.

I have been going to Tuskegee Hospital two or three times a month since September of 1992 for blood test, X-Rays, Cat Scans. My blood test shows that I have Typhoid H.

The Navy would not do anything to help us they told us to go to the VA Hospital. The VA Hospital have done nothing but run test, They will not tell us or give us any test results.

Dr. Jackson at the VA Hospital is my doctor, he diagnose me July 26, 1993 with HTLV-I/II AB Western Blot RGP-21-C. man made Virus, Cancer Causing Virus, He told me that I would have to be

check every three months the rest of my life, the lymph node area I can not give any blood ever, and this virus is highly contagious.

I am real concern about my health, Dr. Jackson said there is no treatment for the virus, only Treatment for the cancer it causes, if it is caught in time.

Dr. Jackson told my Reserve commander there was Ten of the NMCB-74 members, early stages lymphomia cancer and one full blown lymphomia cancer. I have a copy of this letter from Dr. Jackson to my Reserve Commander.

My health is getting worse and I desparately need help or Treatment, I need a answer to what is my problems.

We and I are not getting help from the Navy or the VA Hospital. We need help as soon as possible.

Sincerely yours
Roy W. Marcum Jr

WORK COPY - DO NOT FILE MORROW JR,ROY W 424-62-8394 07/26/93

FORM 10-1338 WORK COPY
TUSKEGEE VA MEDICAL CENTER CLINICAL LABORATORY REPORT

MORROW JR,ROY W 07/26/93 18:39
SSN: 424-62-8394 SEX: M AGE: 46 LOC: PGV

Ordered By: JACKSON,CHARLES E
Specimen: SERUM. SEND 93 1546
05/27/93 10:39

Test name	Result	units	Ref. range
HIV	NON-REACTIVE		

Comment: HTLV I/II AB WESTERN BLOT
FINAL INTERPRETATION [redacted] indeterminant /+ RGP+21

KEY: "L"=Abnormal low, "H"=Abnormal high, "*"=Critical value

Statement of C+P Evaluation and Diagnosis

I am Roy W. Monsanto Jr., I went to Tuskegee VA Hospital 8 apt 17, 1993 for my Compensation and Pension Evaluation, Lab and X-Rays. This was set up through Louisville Ky office, Steven A. Cowles (adjudication officer)

My doctor, Dr. Jackson with the Tuskegee VA hospital, was able to see me that day. Dr. Jackson still told me that I tested Postive with (HTLV-I/II AB Western Blot RGP-21, a man made Virus, Cancer causing Virus.

Dr. Jackson told me after checking my lymph nodes, they were still swollen and he would have to be check every three months the rest of my life and I can not give any blood ever, he told me possibly early stages lymphoma cancer, he could not say if or when it would be full blown lymphoma cancer, he would have to keep a very close watch of the lymph nodes. He did not speak of any Type of Chemotherpay. He said we will watch you very closely.

Dr. Jackson also told me on Sept 17, 1993, he was going to stand behind this Test HTLV-I/II AB Western Blot RGP-21. He even told me that I could go to the News Media, but he wanted me to explain that I have Part of the Virus an outer edge of the Virus (HTLV-I/II AB Western Blot RGP-2

My condition at the Present is totally diffrent then six months ago. Six months ago I was and sick in

all my joints. Today I am partially bump over I can not straighten up at all. I hurt and ache all over, headaches are worse, swollen lymph nodes, night sweats, fatigue and tired at all times, bleeding gums, I hurt memory loss, dizziness, low grade fevers, my eye sight, I have a hard time focusing, rashes, diarrhea, weight loss.

Dr. Jackson diagnose me Chemical and Biological Warfare on Sept 17, 1993. I am waiting for a ratings on my claims now.

I need treatment now, I do not know how much longer I can hold up to work.

Sincerely yours.
Roy W. Morrow Jr.

September 15, 1993

To Whom It May Concern:

My name is Renee Baughman and I am writing this letter on behalf of my husband, Jimmie Baughman, SS# 573-17-9006.

Jimmy was in the U. S. Army for four years. During his enlistment, he served in Saudia Arabia from September 3, 1990 to March 29, 1991 (six months, twenty-seven days). His ETS date was May 7, 1993.

While in the Army, Jimmie became ill. He had symptoms of decreased appetite, weakness, back and leg cramps and easy bruising. He did make several trips to the sick hall but was instructed to go home and rest. These symptoms continued after his discharge from the Army. Once home, Jimmie sought medical attention at Columbus Medical Center, Columbus, Georgia and was newly diagnosed with acute myelomonocytic leukemia. He was then transferred to the Medical College of Georgia, Augusta, Georgia for further evaluation and treatment. Jimmie has since received his first treatment of chemo-therapy and has had bad reactions to his medication.

Since I have been at my husband's bedside, we have lost our home due to having no income. We have two small children, three years and six months old who have been staying with family. WE NEED HELP !! Please help us.

Sincerely,

Renee Baughman

Renee Baughman

Nov. 12, 1993

Mr. Chairman and Congressmen.

As I Nick Roberts stated before you on Nov. 9, 93 about having 173- cases of cancer, brain cancer, braine damage, and also of deaths from cancer . I submit this list of persain gulf veterans as to back my statement up. As I stated there are Names I cannot reveal because many are on active duty and have been threaten. They are scared and sick.
I also state I have no document to back up these names nor proof of there medical condition. These are only vets that have called stateing there problems. Some names were given to me threw a network of other gulf war veterans. Also the media.

I think you will see that this list will show that there is a real problem. I am sure you are getting many such other list of gulf war veterans.
Some of the names may show up 2- times.as calls come in , please excuse this matter. We can,t do everything someone will have to sort out and make a master list.

Thank You for your time.

Nick Roberts
Nick Roberts

Nov.12, 1993

Todd Richmond (319) 351-8339 Surgery now.

Pat Taylor (919) 432-9802 Sick bad. Knows of many others.

Lawrence Hensey (617) 963-8165 Has cancer. Couldn't talk much.

Sgt. Ramos (relative would not leave #) Died of cancer.

Rocky Gonzales (919) 432-1539 Has kidney cancer.

Richard White (405) 352-2062 Died of cancer.

Randy Springs (508) 477-6610 Has cancer.

Mike Moore (205) 298-8085 Navy CB. Thyroid shut down.

Terry Avery (205) 297-8415. Navy CB. Sick wife and kids.

Elvis Rich (706) 568-3546 Has focal atypia/ duodenitis. Navy CB.

Roy Morrow, Jr. (205) 291-5203 Navy CB w/ chemical/biological exposure.

Col. LaDuc (706) 561-5666 Has lung cancer.

Fred Willoughby (706) 327-4305 Navy CB, has colon polyps.

Mike Tidd (706) 322-6072 Navy CB, has night sweats/dizzy spells/headaches.

William Travis (205) 855-4187 Navy CB, has rectal bleeding, wife has problems.

Tom Harper (706) 846-3224 Navy CB w/ early signs of lymphoma.

Roy Butler (706) 563-3095 Navy CB, tested positive for HTLV I & II, has early signs of lymphoma.

Larry Kay (706) 561-5019 Navy CB, chemical/biological exposure.

Gene Trucks (205) 629-5732 Navy CB w/ brain damage.

Sgt. McCain (no number) Has lymphoma/ Is in DC hospital.

Mr. Haines (Father) (803) 358-8790 Navy CB, has brain damage.

Mr. Haines (Son) " " " Navy CB, has brain damage.

Chief Perry (704) 279-7999 Navy CB, has brain damage.

Sterling Simms (205) 833-1445 Navy CB, has brain damage.

Chief Lane, treated by Dr. Hymann (no number)

Clark Edwards (704) 858-6232 Bad medical problems.

Lt. Bottoms (no number) In 644th. Has cancer.

Ed Boscavich (no number) In 644th. Has cancer.

Bill Greig (714) 553-9389 Has cancer.

Mr. Todd (313) 351-8339 Has cancer.

really sick, bad cough, depression, memory loss, ringing ears 24 hrs a day.

Brad Jamison (502) 899-1508 With 1st marine division, saw blisters on 2 Marines during breach of land mines.

Claudia Walter (203) 429-7322 Brother-in-law Drew Dickinson died from lymph node cancer at 48 after being in Gulf.

Maggie Hipp (618) 644-9318 (H), (618) 398-7790 Navy medic with Construction Battalion Hospital Unit 22/ Fleet Hospital 6 based on Bahrain. Knows of half a dozen sick guys from that unit but won't give me numbers yet. She's sick too.

Kelly Decker (914) 856-6999 Was in 105th Military Airlift Group. His job was to shoot the video. He was in and out of Saudi Arabia in Al-Jabar and King Fahd airport, Dhahran and Bahrain. He now has major intestinal problems. Possible leishmaniasis.

Sheila Guy (318) 436-0818 With 194th Replacement Detachment, Navy Reserve from Lake Charles, LA, assigned to 7th Corp Personnel from Germany. Has central nervous system problems.

Marty Alexander (515) 465-5949 With National Guard 1034th Quartermaster Unit based near Hafa Al-Abatm north of Kuwait. Has had sinus surgery/memory loss/respiratory infections.

Tim Striley (815) 589-4382

Bill Rider (814) 237-0947 Has lymphoma.

Jerry Phillips (405) 226-2812 Has chemical sensitivity.

Steve Chung (313) 461-2234 Testing for lymphoma.

James Weathers (205) 687-9423 Testing for colon cancer.

Russell Thompson (803) 379-3099 Has rare muscle disease.

Selina Nelson (405) 355-2751 Has brain damage. (yeah, no kidding!)

Shirley Jackson (617) 232-9500 Being tested.

James Peterson (405) 436-1920

Kirk Burns (409) 760-4373 Has brain tumor.

Mike Lande (714) 968-4330 Has lymphoma. Also knows of 2 others w/ brain tumors.

Capt. Joe Ellis (904) 376-8668 Has bad problems.

Mr. May (cannot give number) Died of brain cancer.

Doug Farmer (800) 241-2663 (Dad) Died of lymphoma cancer.

William McClouster (206) 692-7121 Has lymphoma.

Frank Combs (904) 259-5760 Has lymphoma.

dhanlon Fri Nov 12 17:34 page 1

SLUG	SHOW	WRITER	MODIFIED tvail	TIMING	LC
GULF VICTIMS		tvail	Wed Nov 10 16:37 1993	LOCKED 5:55	224

Jesse Vasquez (512) 882-5415 Sick vet

Ed Creeden (717) 264-6121 (PA) 1st Marine Division Bronchitis/Antidote side effects

Laurie Gallegos (303) 259-4839 Her husband Rocky was in Gulf, now both are sick with fatigue/ sinus problems/ blackouts/ migraines/ shortness of breath.

Bannell White (919) 353-6205 Sick vet

Gayle Teppley (501) 679-5037 Migraines/loss of breathing capacity.

Charles Hicks (813) 537-2373 Sick vet

Peter Wincehster (602) 890-1612 Sick vet in AZ...knows 150 other sick vets.

Dawn Emmert (317) 547-5650 Sick vet and knows others sick/had support group.

Peter Wincehster (602) 890-1612 Sick vet in AZ...knows 150 other sick vets.

Dawn Emmert (317) 547-5650 Sick vet and knows others sick/had support group.

Adrienne Lockstar (410) 377-2910 Has theories on Gulf War Syndrome causes.Dan Valley (914) 897-9554 CBS engineer who was in Gulf with Dan Rather. Called Meaghan in NY to say he was sick.

Mary Lee Ryder (914) 238-5082 (H), (914) 739-1166 (W) Her son William is dying of Gulf War illnesses.

Jinny Hezen (509) 525-4935 Reserve nurse who had antidote shot and then had heart attack and never went to the Gulf.

Beth White (412) 881-4748

Mr. Rhodes (717) 765-0263

Tammy Butler (619) 253-4577

James Smith (313) 896-5790 Nephew has cancer

Shane Avery (614) 998-2593 Same battalion as Brad Jamison, has tape of chemical attack during breach of land mines.

Sandy Balzar (703) 847-0989 Just wants transcript

James Eaton (713) 392-4592 (H), (713) 647-3236 (W) Was in the Gulf right after the war, civilian works for engineering company, now suffers from rash, stomach problems, had thyroid removed.

Fred Whittaker (919) 484-8380/ (919) 391-0134 Army pilot with illness.

Chris Plushart (410) 224-6564 Her husband was there with the 2nd Marines and is sick.

Richard Mejesic (215) 345-0288 Has Hodgkin's lymphoma.

Jamie Owens (916) 782-8106 Her husband was in Navy CHB unit..now

393 P03 [illegible]

David Danials 303 973-6036
Unit: FSSG MARINES
Symtoms: Joint pain, chest pain, cola frequently, sinus, Burning eyes, hard getting up in the morning, Diagnosed NOV. 1990 with personality disorder.ETC.

John Occonal 719 380-8893
Unit: 4th Battalion 70th Armory 1st Armor Division (army AD)
Symptoms: Sinus, breathing problems, mussle and joint pains, Fatigue, etc

MIke Harvey No Phone
1st 82nd Airborne Battalion
Symptoms: Sleep disorders, Hairloss, lower back pain, short term memory, short of breath, suicidal thoughts, assalut charges 2 times since the return from the Gulf weight loss of 40 pounds, etc.

Tim Dilard 303 452-1278
Unit: Unknown at this time (national Gaurd)
Symptoms: Tingling in elbow and arms and spine, sleeping problems.

Richards Oak 303 477-2233
Alpha Company 57th Signal Battalion Army
Symptoms: Loss of Finger nails on left hand, Rashes, Joint pain, Diarrhea, very emotional, sinus problems, suicidal thoughts, uranary irgancy. Etc.

Stephen Shaffer 303 588-2265
Please call for unit and syptoms.

Dennis Wilson 303 247-0384
Unit: Alpha company 7th Battalion, 159th Aviation reg.
4th Battalion 229 Aviation reg 11th bregaid
Symptoms: Short of breath, weight gain, etc.

Tony Calloni 216 671-8991
Unit: 2ND LAAM Battalion Marines
Symptoms: Heart Palpitations, sever rashes, Matalic taste shakes, frequant colds, blurred vision, stuttering, weight increase, bleeding gums, more sensitive to light, mind on fast forward, short term memory, etc.

Rocky Gallegos 303 259-4839
Unit: 2Nd LAAM Battalion Marines
Symptoms: Narcolepsy symptoms, personality disorder sever, aching joint and mussles, head aches, suicidal thoughts, insomnia, animorphis forms in sperm and low sperm count, Verococil operation June 1, 1992, hymroids, sinus problems, nervous disorder un able to keep employment,etc.

Ward Whiteman 719 596-2495
Unit: A Company 7. 159th Farp team 4 229 Army
Symptoms: Personality disorder, Narcolepsy symptoms, diagnosed chemical sensitive, unable to handle authority figures, suicidal thoughts, sever rages, testical pain, night sweats, memory loss, Head aches.etc.

Terry Morrow 303 356-2427
UNit: 3rd Assult Amph. Battalion 1st Marine Division Navy
Symptoms: Fatigue, foot fungus;lost toe left foot because of tumor, sores and rashes all over body, dental problems, bottom gum deteriating, psychological problems, ect.

Charles Edwards Patterson II 303-986-5380
Unit:46th Engineers, Supported 24th infantry Army
Symptoms: Severe headaches, fatigue, rashes, exhaust and cigarett smoke bother him, blisters on tongue, hair loss, diarrhea and abdominal pain, short term memery, act.

Mike Lanning 307-638-0876
Unit: 401st tec fighter wing div.. Air Force (ACTIVE DUTY)
Symptoms: fatigue, body aches, liver problems, CMV disease, testical pain, thyroid and possible diabetes, ring worm type rash.Etc.

Mark Persky 303-343-6426
Unit:3rd Battalion 9th Marines
Symptoms: headaches severe, memory loss, heartburn, shortness of breath, colds, sinus problems, insomnia, short tempered. Etc.

Jill Roathlisderger 303-659-6956
Unit: 31 Fox Switchboard MSU Alpha Company
1st Signal Battalion
Symptoms: Mood swings, fatigue, head aches, diahrea, Has T.B., urinary night urgancy, blurred Vission, increased gas blotting Etc.

Frank Combs -- Testing for lymphoma cancer- glande.- 1-904-259-5760
William Mc Clouster - Lymphoma CANCER---- 1-206- 692-7121
Dough Farmer- died lymphoma CANCER- Dads # 1-800-241-2663
Capt. Joe Ellie- sick, promblems-- 1-904-376-8668
Mike Land -- lymphoma CANCER- knows of others- 1-714-968-4330
Two of mr. Lands freinds has brain tumors.- see above #
Kirk Burns- Brain tumors- Cancer not known yet- 1-409-760-4374
James peterson- says he has important info -- 1-405-436-1920
Shirley Jackson --- would not give number ----
Pete Winchester- sick - testing now- 1-617-232-9500
1-602-890-1612
Sealina Nelson- -- Brain Damage- 1-405-355-2751
Russell Thomason - Rare muslce disease- 1-803-379-3099
James weathers- testing , for colon cancer- 1-205-687-9428
Steve Chung - Testing for glands - 1-313-461-2234
Jerry Phillips - Chemical sencatvity ---- 1-405-226-2812
Bill Rider- - Lymphoma Cancer ---- 1-814-237-0947
Tim Striley- sick - testing now ---1-815-589-4382
Roy Morrow- Dign. Chemical- Biologacal exposure-1-205-291-5203
Elvis Rich- Rare fungus , stomach, rashes-- 1-706-568-3564
Terry Avery- sick - Navy C.B. Columbus Ga. 1-205-297-8415
Terry Avery,s wife- spouse, sick , same #
mr. Averys two children sick- concerned of health same #
Mike Moore- Thyroid shut down in country, Radiation-1-205-298-8085
Mr. Moores wife- Fatique, weak at times, concerned- same #
Mr. Moores daugter- Thyroid promblems- on medicine- very concerned!
Col. La Duc-- Lung cancer-- Ft. Benning Ga. cannot give #
Fred Willoughby- sick , fatique, testnow, on colon-1-706-327-4305
Fred ,s wife showing some of same problems- same # as above.
Mike Tidd- sick - tired, night sweats, dizzy, 1-706-322-6072
William Travis- Heart promblems, rectal bleeding-1-205-855-4187
Mr. Travis ,s wife - having problems- would not go into detail...
Tommy Harper- Enlarged spleen, glands swollen,lmphonathpy1-706-846-3224
Wife having some of the same symptoms. see above. spleen o.k.
Roy Butler - tested pos. htlv. 1-2 , sick vet.---1-706-563-5095
Larry Kay- Chemical- biological exposure---- 1-706-561-5019
Wife showing some of same problems - not all. # above

--PERSAIN GULF VETS --

Gulf Vets - Cancer, Brain damage, sickness, and symtoms.

Charlot Gilbreath- mom, son died lymphoma cancer-contact-1-706-866-2736
Steve Freeman- bone detenation, face gone, cancer- 1-405-536-4148
Delbert Pushert- very sick -- 1-410- 799-7493
Sgt. Major Cancer, on active duty- would not give number.
Rogue Gonzalez- warrant officer- sick-- 1-919-866-6466
Pedro Juarey-- died cancer-- contact-- 1-219-736-5929
Susan Darget- Knows of many sick vets - Camp penniton Calf.
Jeff Taylor- Very sick, Lungs , infections. 1-207-989-4646
Elmor Elliott- 24 th. battalion, very sick, Athens Ga.
Dale Clinton - Permanant lung damage-- would not leave phone number.
Phillip Mc Gill - nmcb- sick
Dale Clover- very sick - Bad sick. cannot give number- active duty.
Fred Johnson- sick- 1-414-675-6496
Don Drake- Rashes, hair coming out, pain, bleeding. 1-205-535-0960
Ward Whiteland- Chemical senaativty -sick,- 1-719-596-2495
Vaughn Kidwell- high white blood count, rashes, 1-619-365-3492
James Eaton- sick --- 1-713-392-4592
Dan Valley- C.B.S. news was there, very sick, bad- 1-212-975-2301
Chris Kelly- says test kit showed mustard gas. 1-805-984-6712
Sgt. vaughn- Ft. Mead - Tumors, very sick.-- 1-410-437-8779
Sgt. Jim bowden- K.K.M.C. says he came in contact-gas.1-205-775-8644
Fred Jones-- Glands swollen, sick, 1-414-675-6496
SOMEONE CALLED AND SAID TO CHECK OUT 844 th. engineers many sick.
Mr. Ferbert - very sick- 181 st. Nat,l Guard- 1-508-697-6230
Lawrance Henessy- lukoplakia CANCER- 1-616-963-8165
Randy Springs CANCER-- Bone, 181 st. Nat,l Guard-1-508-477-6610
Bobby Bell - Lymphoma Cancer-- would not give number.
Nick Roberts - Lymphoma Cancer-- Navy, Ja-Bail. S.A. 1-205-297-3286
Mr. May- died - CANCER -- cannot give number------
Richard White- died - Cancer -- 1-405-353-2062
Rocky Gonzalus- CANCER- kidneys--- 1-919-432-1539--
Sgt. Ramouse- died of CANCER- Relative would not give number.
Pat Taylor-- very sick- knows of others- 1-919-432-9802
Todd Richmound- testing now, glands swollen bad- 1-319-351-8339

Gene Trucks - Brain Damage- 100 % C.B. 24 Batt. 1-205-629-5732
Sgt. Mc cain - cancer ---- in hospital wash. D.C.
Mr. Haines - Dad- Brain damage- C.B. 24 th. Batt. 1-803-358-8790
Mr. Haines- son -- Brain damage- C.B. 24 th. Batt. Same #
Cheif Perry- testing, posibly brain damage- 24 th. 1-704-279-7999
Sterlig Simms- Rashes , sores, fatique, memory loss- 1-205-833-1445
Cheif Lane -- being tested by Dr. Hyman in New Crleans , no #
Willie Hicks- very sick- 644- Maint.
Clark Edwards- very sick - 1-704-858-6232
Lt. Bottoms-- Cancer- very sick - 644 th. Maint. would not give#
Ed Boscavich- Cancer- sick 644 th. Maint. would not give #
Bill Greig- Cancer- cancer--- 1-714-553-9389
Mr. todd --- Cancer- sick - 1-313-351-8339
Mike Addcock- died of lmphoma CANCER--- mom-- 1-904-368-6984
Mr. garcia- Cancer- not good- could not talk much-1-915-757-3302
Nick Roberts - wife, Fatique, memory loss, 1-205-297-3286
Nick Roberts - Daughter- lung infection, 2-yrs. can,t shake it. !
John Canaway- very sick - 1-501-356-3062
Mr. Hurasie- cancer- sick- 1-617-963-8165
Steve Evans - cancer- sick- 1-313-747-6194
Mike Shaffer- Cancer- sick- 1-813-783-1435
Chris Dower- Cancer- many tumors- 1-508-534-0847
Scott Ferenze- sick - testing now- 1-904-593-5567
Bennel White- Bad sick 1-919-353-6205
Mr, dillard - Cancer, 1 st. calv. Gainsville Fla. would not give #
Sara Hawkins- died of Cancer- contact- 1-904-684-2228
Larrea Rosalius- 209 th. supp. Sick- 1-815-683-2537
Mr. Larifey - lymphoma Cancer- sick- 1-215-343-0826
Jim bowman - leukimia- cancer- not doing well-- 1-205-297-2756
Brett Walker- died cancer- moms # 1-313-724-8381
Jim Cancer- no- info - CK. # 1-704- 456-6263 ?
Lenord Lynn- Lung problems, night sweats,pain- 1-205-687-4956
Rocky Gallegoes- sick - wife also sick - 1-303-259-4839
Larry Pearson - C.B. concerned, smptoms- 1-706-687-8078
Mike Shepard- sick , joint Pain , C.B. 24 th. Batt. 1-706-882-5813
Russell Owens - Fatique,swollen glands, sick. 1-706-568-4988
Robert Nesselrotte- fatique,sweats,dizzy,pain- 1-706-323-4443

ike Adcock (904) 368-6984 (Mom) Died of lymphoma.

r. Garcia (915) 757-3302 Not good at the moment.

ohn Canaway (501) 356-3062 Very sick.

r. Harasie (617) 963-8165 Has cancer.

teve Evans (313) 747-6194 Has lymphoma.

ike Shaffer (813) 783-1435 Has cancer.

hris Dower (508) 534-0847 Has cancer and many tumors.

cott Fereny (904) 593-5567 Bad problems/ swollen lymph nodes.

r. Dillard (no number) With 1st Calvalry, Gainesville, FL. Has cancer.

arris Rosaliule (815) 683-2537 With 209th Supply Co./ very sick.

r. Larrifey (215) 343-0826 Has lymphoma.

im Bowman (205) 297-2756 With 197th at Ft. Benning/ has leukemia.

rett Walker (313) 724-8381 (Mom) Died of cancer.

im ? (704) 456-6263 No info.

gt. George Vaughn (410) 437-8779 Army Sgt. fighting a medical retirement. He is sick.

Brian Baker Gilbreath (706) 866-2736 (Mom Charlotte) Died of lymphoma at age 28 in mid-1993. Was with 844th Army Engineers of Chattanooga, TN.

Dr. Don O'Brien (no number) Retired. Lt. Col. who is sick. From Storm Lake, Iowa. Buena Vista College.

[redacted] (815) 945-7399 With the 233rd MP's attached to the 1st Infantry [redacted]

Kirk Burns- 101 st. brain tumors- more test-- 1-409-760-4373
Howard Johnson - Lump under arm pit-tired- 1-706-846-9332
Gary Johnson- sick, fatique, C.B. 24 th. Batt. 1-205-291-9570
Bill Mc Daniel-- Fatique- concerned-- 1-706-2443
Michael l. Caughey- Night sweats, sinus problems- 1-706-989-3275
Lonnie Land- - rash, fatique, headaches,-- 1-205-899-4213
Dale Glover- N.C.O. Chemical field, tumor, - 1-205-295-8127
Tom Muse- Rashes, Fatique, C.B. 24 th. Batt. 1-205- 323-1464
Anthony picou- - sick- 1-210-658-7870
Elizabeth Jones--- Died Kidney failure- 121 th. trans. unit.
(CANCER)
Bob Wages-- Sick, several symptoms, Fox commander, 1-205-480-2081
(Told posible early luikemia cancer)
Steven A. Schaefer- died V.A.-day cancer- wifes # - 1-303-588-2266
Cheryl M. Guy-- sick, dizzy spells, nervous system- 1-318-436-0818

Charles Body - Joiny Pain-Rashes, Swollen glands, cannott give #
Betty Turner-- Rashes, Joint pain, Fevers, cannot give #
Richard Haines- sick - 1-812-948-9366
Phillip Owens -- Chest pain, Infectione , 1-916-782-8106
John Ferbert- Non- hodgins lymphoma- sick-- 1-508-697-6230
Harold Rhodes-- Rashes, Fatiquw, sick-- 1-717-765-0263

Nov. 10, 93

Mr. Chairman

This statement will prove and back the statement I made on Nov. 9, 1993 . I Nick Roberts Made claim that I had to obtain an attorney to get my medical test results from the V. A. hospital in Tuskgegee Al. after failing to on my own. It took only 1- year and aprox. 2 months to finally get my records. My records also showed in Nov. 2, 92 I had swollen lympth glands, low fevers , rashes, dizzy spells.

Affidavit ie attached.

Copy of certain medical records are also attached.

Thank you
Nick Roberts Nick Roberts
Nov. 10, 93

AFFIDAVIT, POWER OF ATTORNEY AND RELEASE FOR MEDICAL RECORDS

My name is Nicholas Eugene Roberts. I have been examined and treated at the Veteran's Administration Hospital, Tuskegee, Alabama, for injuries and diseases resulting from combat duty in Saudi Arabia during the years 1990-1991 as a member of N.M.C.B. 24. I desire and request of the Veteran's Administration Hospital that a copy of all medical records of all tests performed, clinical examinations and evaluations, laboratory testing and data, history and physical notes, examinations, treatments, evaluations, doctors' impressions and diagnoses; all correspondence between the environmentalist physician, C. Jackson, M.D., and any and all Veteran's Administration, Navy Department, Army Department, and Walter Reed Hospital personnel; all records or schedules demonstrating scheduled examinations (including blood gathering) to be performed on August 21, 1993, and/or August 28, 1993, at the Naval Training Center, Columbus, Georgia; all correspondence between any physician or administrative personnel of the Veteran's Administration Hospital in Tuskegee, Alabama, and any other party including the Veteran's Administration, Washington, D.C., United States Navy Department, Washington, D.C., Commanding General Ronald Blanck, Walter Reed Army Medical Center, Washington, D.C., United States Public Health Service or any of its subsidiaries concerning me or any other member of my Naval Reserve Unit N.M.C.B. 24; all records at Veteran's Administration Hospital, Tuskegee, Alabama, of my being afflicted with Lymphadenopathy, Lymphoma, Hepatitis A and Hepatitis B, immunity problems manifested with serum

immunoelectrophoresis, and viruses of the HTLV-I/II categories; all correspondence canceling blood gathering from me scheduled for August 21, 1993, and/or August 28, 1993, at the Naval Training Center, Columbus, Georgia; all records of Dr. Rollins, all records of Dr. Rebea, and all records from Bureau of Medicine (BuMed) of the United States Navy having reference to any treatment or examination or disease for which I was examined or diagnosed while at the Veteran's Administration Hospital in Tuskegee, Alabama, be provided to my attorney, Frank O. Burge, Jr., 2300 SouthTrust Tower, Birmingham, Alabama 35203, and, by these presents, I do hereby authorize and appoint him my duly attorney in fact to receive these records from the Veteran's Administration Hospital, Tuskegee, Alabama.

Done at Birmingham, Alabama, this the 16 day of September, 1993.

Nicholas Eugene Roberts
NICHOLAS EUGENE ROBERTS

STATE OF ALABAMA)
JEFFERSON COUNTY)

Before me the undersigned authority in and for said County and State, personally appeared NICHOLAS EUGENE ROBERTS, who is known to me and who after being by me first duly sworn, states that the facts set forth in the foregoing Affidavit are true and correct.

This 16 day of September, 1993.

Nicholas Eugene Roberts
NICHOLAS EUGENE ROBERTS

Sworn to and Subscribed
before me this the 16
day of September, 1993.

Jane H. Blalock
NOTARY PUBLIC
MY COMMISSION EXPIRES: 5-17-94

[redacted]: NOV 16,1992 Compensation and Pension Exam Report Page: 1
TUSKEGEE
** FINAL **

For GENERAL MEDICAL Exam

Name: ROBERTS,NICHOLAS E
SSN: 257906104
C-Number: 257906104
DOB: JUN 26,1954

Address: 3 PINE RIDGE ESTATES

City,State,Zip:
PHENIX CITY ALABAMA 36869
Res Phone: 205-297-3286
Bus Phone: 205-297-4644

Entered active service: DEC 3,1990 Last rating exam date:
Released active service: MAY 4,1991

Priority of exam: Original SC

Examining physician: M. V. SALAMANCA, M.D.
Examined on: NOV 2,1992

Examination results:

A. OCCUPATIONS:

B. MEDICAL HISTORY:
1. THIS 38 YEAR OLD WHITE MALE WAS IN DESERT STORM FROM DECEMBER 1990 TO MAY 1991. ON HIS RETURN HE NOTED A RASH ON HIS LEFT LEG IN JANUARY 1991. IT IS A DRY PATCH WHICH IF IRRITATED WILL BLEED. HE WAS GIVEN SOME OINTMENT WHICH CLEARED THE LESION.
2. WHILE IN SAUDI, HE WAS GIVEN MANY SHOTS AND PILLS TO TAKE. THE SHOTS AND PILLS MADE HIM HAVE DIZZY SPELLS ON AND OFF WHICH PERSISTED EVEN UP TO NOW. ALSO HE STATES GETTING TIRED EASILY, HAS ACHING IN HIS JOINTS, FEVERISH AT TIMES AND ALSO SOME LOSS OF MEMORY.

C. PRESENT COMPLAINTS: RASH - ITCHES, BURNS, BLEEDS

D. HEIGHT: 74" WEIGHT: 165 BUILD/NUTRITION: WELL DEV. WELL NOURISHED
TEMP: 96.6 TIME: 9:05 CARRIAGE: NORMAL POSTURE: ERECT
GAIT: NORMAL RIGHT HANDED, ASKED

E. SKIN: TATTOO BOTH ARMS AND UPPER CHEST. NO LOCALIZED PATCH WITH MACULAR ERUPTION LEFT LEG

F. LYLMPHATIC AND HEMIC: PALPABLE LYMPH NODES BOTH INGUINAL AREAS, WITH MILD TENDERNESS, ALSO ON CERVICAL AND ANXILLARY AREAS

G. HEAD, FACE AND NECK: NORMAL

H. NOSE, SINUSES, MOUTH AND THROAT: NORMAL

I. EARS: NORMAL

(5)

Medical Center Tuskegee, AL 36083

Veterans Administration

Dear Commander,

This letter is a follow up of the telephone conversation of last week. As was discussed, the members of your unit have medical problems which appear to be different from those that are being observed by other Persian Gulf War veterans, namely lymphadenopathy and lymphoma. It now appears that there are a number of members of the 24 th Battalion who were stationed naar Al Jubayl on the coast of Saudi Arabia who are experiencing these same physical abnormalities. With your permission we plan on testing the members of your unit who went to the Gulf. Specifically, we will be testing for evidance of Hepatitis A and B, immune problems as manifest with an immunoelectrophoresis(serum) and for viruses of the HTLV-I/II category.

You suggested that august 28 would be a good date for drawing the blood. It has been suggested bY one of the members of your unit that we also come on August 21 as many members will be present on that date and not on August 28. If this is acceptable with you, we will come on both dates,since the number of individuals will be smaller on each date, the entire length of time that we will have to interfer with your unit activities should not exceed one hour on each date.

Please notify by phone which option is acceptable with you; one visit-please designate date-or two visits.

Thank you

C. Jackson M.D.
Environmental Physician
Out Patient 11 A
V.A. Hospital
Tuskegee, Ala. 36083
Tele # 205-727-0550 ext. 3380,3370

In Reply Refer To:

Nov. 14, 93

Mr. Chairman and Congressman.

It has been said by Generals and even a President that we were Americas best. We were told we were the best trained , best equipped, and also the best physically trained troops in the world. It is appearant something is very wrong. Seems we were not trained as well as we thought. We did not know how to detect or read chemical test kits corectly. Now for some reason all of the chemical detection devices and test kits we had did not work properly. Now we are finding many gulf veterans have post dramatic stress and many have been told we needed psychiatric help. You mean to tell me that the United States sent to war ill, untrained , stressed out mentally and in need of psychiatric help. Thats a crime in it self.
I can asure you that if the need came again for me to go to war , I would most certainly want the same expertise of all gulf war veterans on my side. Congressman , you have heard from veterans on earlier dates as you are about to hear others. You are indeed hearing from americas best, remember our statis in the milatary was high, and we have great respect for patiotism. Its hard to stand by and watch your comrades fall and be treated with no respect. Our testamony and the facts of what happened durring the gulf war will surly come together and show that maybe the troops were,nt the ones needing psychiatric help .
I certainly would not under estimate us. Listen and you will get the fill of what did happen, so as as the weeks pass and more come forward you will see we have set the stage as care full as the pentagon. It seems as if we play some sort of game. we come forward , then they do , and so on. we are at a good pace now, Butt , you will see that pace begin to move even faster. All we want is the truth, and know if we can get medical help.

Thanks. Nick Robata

BRIEFING FOR CONGRESSMAN MAC COLLINS

September 13, 1993

1416 Longworth H.O.B.

BRIEFERS:

Captain S. William Berg, USN	NEPMU 2
Captain Steven Cunnion, USN	BUMED
Colonel Rick Erdtmann, MD, USA	US Army Surgeon General's Office
Colonel Reginald G. Moore, MD	J4-Medical Readiness Division
CDR James L. Bullock, USN	NAVFACENGCOM
Mr. Denny Ross	DIA Chemical Expert-requested by J2
LTC Glenn Baker, USA	JCS
LTC Patty Hamill, USA	OSD-Reserve Affairs

LEGISLATIVE AFFAIRS:

Capt. Bob Shields	JCS-LA	703-614-1777
Tamara Crail	OSD-LA	703-697-8784
Betty McGraw	BUMED-LA	202-653-0157
LTC David Schock	USA-LA	703-697-9690
LCDR Pam White	USN-LA	703-697-6196

REPRESENTATIVE MAC COLLINS (GA-3)

Following is a list of questions that I provided to the Office of the Secretary of Defense. On September 13, 1993, I met with various officials from the Department of Defense to discuss these questions:

1. Does the OSD have any indication that chemical or biological weapons were used against U.S. troops in Al-Jubal, Saudi Arabia on January 20, 1991 or at any other time?

2. If there was any possibility that these troops had been in contact with chemical or biological weapons, were they briefed as to this possibility?

3. Why did alarm signals go immediately to MOP level 4 at the time of the attack?

4. Why was all chemical gear taken by the military following the attack? Does this indicate that the gear had been contaminated? It is my understanding that chemical protective suits, can be safely re-used for up to six months if they have not been contaminated, is this accurate?

5. Were CBs or any other troops ordered to de-contaminate military vehicles, etc..., following this attack? If so, why?

6. It appears that the Department of the Navy is removing the doctor who diagnosed these CBs from their case. Is that true? Why is he being removed from their case?

7. Why are the CBs blood tests, and other medical procedures being postponed?

8. The CBs believe that an attempted cover-up is taking place. They are suffering from lymphodemopathy, lymphoma and they will likely end up with Human T-Cell deficiency and Lymphoma-Leukemia. Their symptoms differ from diagnosis of other, non Al-Jubal, Gulf War Veterans. Does this give OSD reason to believe that they possibly were subject to chemical or biological attack?

9. Would it be possible for me to review the reports which these CBs filled out for their medical records when they returned from the Gulf? If Saudi Arabia related materials have been removed from their files, why was this done?

10. The virus that these CBs have contracted has been diagnosed as highly contagious. The wife of at least one of these CBs has also tested positive with this virus, and others are experiencing similar symptoms. What is being done to provide medical assistance to dependents of these CBs?

11. If these individuals were subjected to chemical or biological weapons, what sort of medical treatment and follow up is recommended by the Office of the Secretary?

I am making no assumptions in this case and at this time consider it to be confidential. However, I do want to ensure that these individuals are given the medical attention that they deserve.

MAC COLLINS

OTA TESTIMONY

Statement of

Hellen Gelband, Senior Associate

and

Maria Hewitt, Senior Analyst

OTA Health Program

accompanied by

Clyde J. Behney
Assistant Director
Health, Life Sciences, and the Environment

Before the
House of Representatives Committee on Veterans' Affairs

November 16, 1993

The Persian Gulf Health Registries

Congress of the United States
Office of Technology Assessment
Washington, DC 20510-8025

Summary

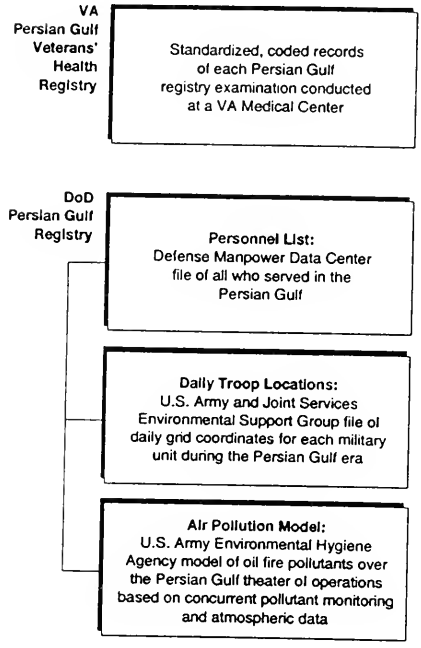
Thank you for giving OTA the opportunity to present testimony at this hearing. I am Hellen Gelband, Senior Associate in the OTA Health Program, and with me is Maria Hewitt, a Senior Analyst, also in the Health Program.

When Congress directed the U.S. Department of Veterans Affairs (VA) to create a registry for health examinations of Persian Gulf veterans, the greatest potential hazard appeared to be smoke pouring from hundreds of oil wells that had been set on fire by the Iraqis. The U.S. Department of Defense (DoD) list of Desert Storm/Desert Shield participants and the locations of their units in relation to oil fire smoke--the other piece to this registry complex (see figure)--also was driven singularly by concern about the effect of the fires on veterans' health, not only in the short run, but for years afterward. In addition to its role in providing comprehensive medical examinations to concerned Persian Gulf veterans, the VA registry was conceived as a means to identify "sentinel" conditions possibly consequent to Persian Gulf service. Because the registry comprises veterans who either have health problems or are particularly concerned about their health--not a representative sample of veterans--analyses of the registry data cannot, themselves, provide clear evidence of a link between Persian Gulf exposures and any specific medical condition. But conditions seen in registry participants could provoke suspicion of a link, which could then be investigated in a formal epidemiologic study.

The law mandating creation of the VA registry also mandated this Office of Technology Assessment (OTA) assessment and, in the long term, set up an arrangement for review of the registry data by the Institute of Medicine's Medical Follow-Up Agency (MFUA). It is MFUA that will have the difficult task of recommending when in-depth studies should be considered.

Once completed, the registry complex may be used in various ways to consider possible health damage from the oil fire smoke. DoD will be able to answer questions from individual veterans about their level of exposure using daily company locations and modeled data on air pollutants. The DoD registry also could be used to identify cohorts of individuals with relatively high and relatively low exposure to oil fire pollutants, should it be desirable to do so for the purposes of an in-depth study. The

FIGURE: The Persian Gulf Registry "Complex"



emphasis on oil fires as the exposure around which the registries are constructed, however, means that they will be much less useful for exploring other potential hazards, except those with known geographic distributions or those that may be unique to certain units or military occupations.

The limitation of the registries, which have been conceived in accordance with congressional mandates, are worth noting. In the VA registry, only relatively rare or unusual conditions, or more common conditions occurring at extremely high rates, will stand out against background rates. In-depth studies of factors other than oil fire smoke, other strictly geographic variables, or possibly those associated with military occupations, will not be facilitated by the DoD registry. Information on exposures other than oil fires would have to be collected on an ad hoc basis, and may not be possible to document. Already, concerns about inoculations, depleted uranium, vehicle paint, diesel fumes, and chemical warfare agents, to name a few, have surfaced. Whether or not these represent real threats, they must, at the very least, be acknowledged and considered for further evaluation. It should be stressed that data from the VA registry can provide only descriptive information about that self-selected population. While the registry population can and should be compared with a similar group not enrolled in the registry, that comparison cannot tell us about a relationship between serving in the Persian Gulf and the occurrence of health conditions.

Some near-term activities that could improve the quality and overall utility of the VA registry are discussed in the body of this background paper and include:

- VA making changes in the collection of medical history and exposure information for the Persian Gulf War Veterans Health Registry;
- VA and DoD standardizing terminology used in their respective registries;
- supplementing the existing coordination and cooperation between DoD and VA to enhance compatibility of the registries by appointing a single Advisory Board to oversee both activities;
- DoD assembling qualitative information about the Persian Gulf conflict, including the distribution of other "exposures" and the specific activities of military units; and
- DoD and VA each cataloging and describing other health-related information available for Persian Gulf veterans from before, during, and after their tours of duty.

OTA'S MANDATE TO ASSESS THE PERSIAN GULF REGISTRIES

OTA's mandate for this report comes from Public Law 102-585, which charged the Director of OTA with assessing "the potential utility" of the DoD and VA registries for "scientific study and assessment of the intermediate and long-term health consequences of military service in the Persian Gulf;" the extent to which the registries meet the requirements of the law; the extent to which the data are being collected and stored appropriately; how useful they would be for scientific studies; and related operational questions. The law calls for separate OTA reports on the VA and DoD registries.

This first report focuses on the VA "Persian Gulf War Veterans Health Registry," which is referred to here as the "examination registry." The second report, due in February 1994, will report on DoD's "Persian Gulf Registry," which is actually the combination of three unique pieces: 1) a list of all individuals who served in the Persian Gulf, 2) daily locations for each unit (probably at the company level) during the Persian Gulf era, and 3) daily oil fire smoke pollutant levels modeled for the Persian Gulf theater of operations during the period when the wells were burning. The registries have distinct and separate functions, but they also must be compatible so that information from the personnel registry can be retrieved easily for individuals in the VA registry. For this reason, we refer to the VA and DoD activities together as a "registry complex." The interrelated nature of VA's and DoD's work necessitated OTA beginning to examine DoD's efforts in order to evaluate VA's registry properly. The result is that some of the conclusions in this report apply both to DoD and VA, and some to DoD alone. The second report may also refer back to VA activities.

A small group of experts in epidemiology, statistics, medicine, and toxicology assisted OTA with this evaluation at a July 29, 1993 workshop. The Institute of Medicine (IOM) also was represented by the Director and staff members of Medical Follow-up Agency (MFUA) and a consultant statistician. The morning consisted of presentations from the DoD and VA offices engaged in registry activities. DoD also briefed the group on several studies bearing on Persian Gulf veterans' health that they have been carrying out, which have already produced useful information and which should continue to do so.

CURRENT STATUS OF THE VA EXAMINATION REGISTRY

VA began offering a Persian Gulf medical examination in early 1993, consisting of a brief medical history, some questions about exposure to oil fire smoke in the Persian Gulf, a complete physical and general laboratory tests and optional special tests (e.g., for lung function) and referrals. The examination is available at all VA medical centers. Two physicians at each center, the designated "environmental physician" and specified alternate, are charged with conducting the examinations. Three referral centers have been established, in Washington, DC, Houston, and West Los Angeles, for cases not diagnosable at the local centers. The Houston site has a special focus on multiple chemical sensitivity, and leishmaniasis cases are being seen in Washington, DC.

Examination results are recorded in the veteran's medical record and selected information is entered on a 2-page registry form that is sent by the VA medical center at which the examination takes place directly to a central processing center in Texas where the data are keyed into the registry file. The VA reports that this basic arrangement is similar to the agent orange and ionizing radiation registries.

Early on, the VA developed an addendum to the examination to elicit a more detailed medical history, mental status, history of exposures and experiences in the Persian Gulf,

and various other pieces of information. The addendum is being administered to only a sample of veterans in a pilot trial. The VA intends to assess the usefulness of the addendum with the help of an existing "blue ribbon panel" or a successor to it, a permanent advisory committee that has not yet been appointed.

As of June 30, 1993, about 8,000 Persian Gulf examinations had been conducted and about 6,000 had been recorded in the electronic database.

VA has encouraged Persian Gulf veterans to take advantage of the examination in a number of ways. Posters have been placed in all VA medical centers, mobile displays have been sent to various places, the veterans' service organizations have been notified, and a Persian Gulf newsletter has been produced. Letters have been sent to all veterans or their survivors who have been compensated for Persian Gulf-related problems, notifying them of their eligibility for the registry (presumably, the existing medical records for these individuals would be used in place of a new examination). VA workers have been instructed to offer the special examination to Persian Gulf veterans who come to medical centers for treatment or other services. Information on Persian Gulf veterans can be included in the registry only with their consent, however (except for deceased veterans, who may be included without consent of their next-of-kin, according to VA).

COMMENTS ON THE VA REGISTRY EXAMINATION PROTOCOL

An important function of the VA examination is to provide veterans with a comprehensive medical checkup and to investigate particular complaints. The protocol in use seems to fulfill this need. However, striking the right balance for collecting information that will be useful as a surveillance tool over the long term is more difficult. A useful guidepost for deciding about what to include or exclude is the desire to keep the registry simple and avoid collecting data that are not justifiable given the limitations of the sample. Information related to health status should be collected as precisely as possible, but effort collecting information on exposures, for which no control group is available, would be wasted.

Some specific problems related to the examination protocol and the coding sheets, particularly for their surveillance value, are identified in Appendix A of the OTA report. This section discusses general concerns with these items.

Medical and Personal History

The current protocol is somewhat weak on medical and personal history, which is covered in great detail in the addendum. The addition of some history questions is justified (e.g., smoking history and civilian occupational history), but there may be too many in the addendum. Resolution of this issue requires a vision of what the information will be used for, beyond any immediate use in dealing with the veteran's medical problems. Even if it may be of immediate use, it may not be of long-term value, so may not need to be a permanent part of the registry (presumably, much more information is generated during the examination and recorded on the medical record than is actually coded).

Health Status Information

The value of the registry to detect sentinel health conditions depends entirely on the medical information captured in the system, but the coding form places strict limits on how much of this information will enter the registry. There is room to write in and code only three complaints and three diagnoses. Even a simple recording of the **number** of complaints a veteran has is limited to five (an entry of "5" denotes five or more complaints). People reporting with what

has been termed the "mystery illness"[1] may have more than five complaints, and this information would be lost. Nor are there instructions in the Coding Manual to guide a physician about how to choose which three complaints to write out. VA should consider making sure that **all** relevant medical status information is captured in the registry and that the amount of this important information is not limited arbitrarily (i.e., all complaints and diagnoses should be written out and coded). The basic form need not be made unduly long if a form can be added for people with many complaints. Losing this information is not acceptable.

Exposure Information

An attempt is made in the current examination protocol to collect information about exposure to oil fires using six questions (e.g., "I was enveloped in smoke," and "I ate food or drink that could have been contaminated by oil or smoke"). Answers are graded from "definitely yes" to "definitely no." A number of questions about other experiences and exposures during Desert Shield/Desert Storm service are in the addendum. Other than asking veterans what they think might be the cause of their conditions, and possibly what other exposures or experiences in the Gulf are worrisome, there is reason to question whether any of this self-reported exposure information will prove to be of value. Unless it can be justified in terms of potential surveillance use, VA should consider dropping it and limiting any other exposure questions from the addendum. If these questions are kept, the wording should be reviewed for clarity (e.g., a veteran might answer "yes" if he or she was heavily exposed to passive cigarette smoke).

Standardization

Given that this examination is being offered at all 171 VA medical centers around the country, a general concern is the problem of standardization. VA does provide training for environmental physicians using the protocol, but the written instructions may not be sufficient to ensure an understanding of what is expected. The examples described above related to medical status (no instruction on how to select which complaints and diagnoses to code) and exposure (no instruction on how to elicit why the veteran thinks he or she might be ill) illustrate the potential problems that might arise if physicians at different centers are inclined to make different choices.

Protocol Revision Process

VA has indicated that it will seek the advice of an advisory group to evaluate the addendum and agree on a final protocol. This would be a very useful approach. The advisory group must be chosen carefully for this particular task, however, including sufficient medical and epidemiologic expertise to evaluate each item critically, both in terms of the validity of the question and of the potential value of the information collected. Information on exposures and the various psychological questions on the addendum are of particular concern. The issue of standardization among centers also should be considered. As discussed in the section below concerning coordination between VA and DoD, it is important that each item, particularly those relating to military experience and demographics, be reviewed with DoD input for consistency with the data in their personnel registry. A decision also must be made about whether to go back to those veterans (either in person or by mail or telephone) who already have been examined to seek additional information.

[1] The "mystery illness" denotes a variable group of symptoms reported by members of the 123rd Army Reserve Command after their return from the Persian Gulf. The "outbreak" was investigated thoroughly by the Walter Reed Army Institute of Research and reported on in a June 15, 1992 report.

STRENGTHS AND LIMITATIONS OF THE REGISTRY COMPLEX

Strengths

One factor that distinguishes this registry from others that rely on self-referrals is that the reference population--all Persian Gulf veterans--is known. A Defense Manpower Data Center (DMDC) electronic file lists all those who served in the Gulf, including reservists and those still on active duty, and contains a set of demographic and military information about each. It should be possible to compare the registry population with a sample (or possibly the entire) population from the DMDC file to find out how different or similar they are. This could be useful to MFUA in its judgments about the medical conditions reported.

Limitations

While the registry complex can serve a useful purpose, the limits of what can be achieved are substantial. First and foremost, it cannot be used to determine cause-and-effect relationships. It never will be possible using the registry to say that any particular condition is caused by a particular exposure or event that happened in the Persian Gulf. At best, it will play the role of case reports in medicine, alerting VA and MFUA that veterans believe they may be suffering effects of Persian Gulf service. It is probably safe to say that for many conditions, no suggestive link will be found. For others, a decision will have to be made whether to pursue a potential link through focused epidemiologic studies, considering both the strength of the suspicion and the feasibility of acquiring the necessary exposure information.

People reporting to the registry will not be representative of the population of Gulf veterans, a point of which Congress was aware when it mandated creation of the registry. Veterans presenting for the examination are either suffering from a condition or concerned for other reasons about their health. This much is obvious. But it should also be pointed out, based on experience with other registries, that the makeup of the registry population may well be influenced by external factors, including stories in the news about particular problems being experienced by veterans. So even what appears to be an unusual number of cases (in proportion to the total registry population) with a particular diagnosis or symptom may not represent an excess in the veteran population as a whole. A question on the registry form asking what prompted the veteran to seek an examination might be helpful in understanding the distribution of conditions reported. The difficult task is sorting out the conditions that may actually be linked to Persian Gulf service from the unlikely ones.

CONCERNS ABOUT COORDINATION OF VA AND DOD ACTIVITIES

Coordination between VA and DoD is taking place, but it may not be sufficient to ensure that, at a practical level, the registry complex can be most effective. Coordination activities should take place among the people responsible for the tasks involved, but a joint VA/DoD permanent oversight group with responsibility for both registries may also be needed.

Three main areas could benefit from increased coordination: 1) ensuring that both veterans and those on active duty have the opportunity to enter the registry; 2) ensuring consistency in the personal identifying information in the two registries so that they can be linked easily; and 3) ensuring consistency of data elements between the two systems where appropriate and eliminating redundant information from the VA registry. These three topics are discussed briefly below.

According to the law, active duty military personnel who served in the Persian Gulf should have the option of entry into the registry. Thus far, very few individuals on active duty have been included, and this lack appears to be due in part

to lack of facilitating administrative arrangements. The number of people on active duty who would avail themselves of this opportunity may be small, but their option should not be foreclosed. In addition, it would be useful for information on inpatients (either active duty or retired) with Persian Gulf service who are treated at DoD hospitals to be available for review by VA and MFUA, if it is possible for DoD to provide this. Some agreement between DoD and VA may be required for this to happen.

A number of items on the VA coding sheet correspond to information on the DoD file. To the extent possible, the items should be collected in a consistent fashion. For example, the codes for race/ethnicity on the VA form are different from those used by the services, and do not allow the range of choices that might be desirable. The personal identifiers (mainly name and Social Security number) may be recorded appropriately for cross-matching the VA and DoD files for individuals, but it is not clear that there has been consultation on this. In addition, military unit is recorded differently in the VA and DoD registries. The VA registry form asks for the veteran's unit by **name** (e.g., Company C, 1st Battalion, 4th Army), while the DMDC database classifies the units using an alphanumeric code that is unrelated to the names. Translating one to the other is not a complicated task, but it is not obvious where it will take place or who will do it, should it be necessary.

This information would serve as a better cross-check if it were consistent. (The Office of Management and Budget has issued a directive with standards for collecting race and ethnicity information, which might be used for this purpose.) Other information, such as military history, is available from the DoD personnel registry, taken directly from each individual's personnel file. It may not be necessary for the veteran to recount this on the VA form. It probably would be beneficial for each item on the VA form to be reviewed with DoD to assure consistency and to evaluate whether it needs to be collected at all. If there is a question about possible errors in the DoD file, VA could arrange with DoD for a printout of the DoD file to be sent to each veteran in the registry for corroboration after the examination.

OTHER EXPOSURES OF INTEREST

Discussion and concern about exposures other than oil fire smoke already are apparent. They have been brought up at congressional hearings and in print; included are depleted uranium, inoculations, an anti-nerve gas compound (pyridostigmine), exposure to petrochemicals in other ways (e.g., diesel fumes from tent heaters), pesticides, microwaves, infectious agents (e.g., leishmaniasis, malaria), chemical warfare agents (though there was no known use), a special paint, and others. Additional concerns are bound to surface in the coming years. Unlike oil fire exposure, where exposure estimates will be based on recorded information, finding out about many other exposures may depend on personal recollection.

Qualitative History of Persian Gulf for Exposures

It is not possible, nor would it necessarily be desirable, to gather individual, detailed data on a large number of exposures or experiences that occurred in the Persian Gulf, just in case they become important later on. The general environment and the military activities were complex and data on the occurrence and distribution of exposures are generally not easy to get. Some basic information about unit movements and activities and about the range of activities of individuals could be gathered now--in the form of a "qualitative history"--and could serve as a reference later on. If this is to be undertaken, it should be done soon. At least some of the information needed is "labile" and will become more and more difficult to ferret out and verify with the passage of time.

Items that should be covered in such a report include:

- *Unit-by-unit descriptions of locations and activities.* Base locations will be available from the DoD registry, but the dally activities will not. It could become important to know when units engaged in combat and how heavy the fighting was. Some idea of the amount of ammunition used might be helpful, for instance. In addition, it would be useful to know how much dispersion there was within a unit on a given day. While it will not be possible to quantify this or to describe it on a day-by-day basis, but at least a relative sense of dispersion by type of unit or location would be useful. It could be important to know this if a geographically described exposure is being considered, given that locations for individuals in the DoD database are represented by their unit (probably company) locations only.
- *Descriptions of the range of activities by military occupational specialty (MOS).* While MOS defines an individual's activities to some extent, it is not adequate to describe the range of activities and exposures of any individual. With specific exposures in mind (e.g., degreasers, diesel fuel), it would be helpful to know what people actually did in the Persian Gulf.

Getting the information for this report would involve a combination of research in military records, possibly other government documents, probably personal interviews with key individuals, and sample surveys of veterans to elicit their personal experiences and exposures. One caution is that individuals, particularly in military situations, may not know about many exposures (e.g., if insecticide is sprayed one day and troops enter the location the next, they will not necessarily know the spraying had been carried out). It is important, to ensure credibility, that a mechanism be developed to allow input and review from a representative group of veterans before the report is issued. In addition, the report should be written so that it is readily understandable by individuals not schooled in military operations.

OTHER SOURCES OF INFORMATION ON HEALTH PROBLEMS OF PERSIAN GULF VETERANS

It has become clear that potentially useful information on current health problems of Persian Gulf veterans, whether or not they are attributable to their service, resides in places other than the VA registry. It will be important for MFUA to be aware of this information and to have access to it for their periodic reviews. This includes new health records, information already recorded in the veteran's DoD or VA files, and results of ongoing VA and DoD studies of Persian Gulf veterans.

Some sources have been brought to OTA's attention. For instance, discharge diagnoses are recorded for inpatients treated at VA hospitals and Persian Gulf veterans are specifically identified in that patient treatment file. In an analysis provided to OTA, VA researchers listed the distribution of all major diagnostic categories for Persian Gulf veterans and a similar-sized group of Persian Gulf-era veterans (who had not served in the Gulf).

The deaths of most veterans are reported to VA and logged in a system that records all compensation claims. Copies of death certificates usually are submitted, and these could be available for review. While relatively few deaths would be expected in this young population, they would represent the most serious conditions.

There may also be valuable information in DoD personnel and medical records and laboratories (e.g., induction physicals and psychological testing, stored serum samples). It is important to researchers for the design of future studies, should they become necessary, to know just what sources of data exist for these individuals.

A description of these sources including data from before, during, and after Persian Gulf service could be made available from DoD and VA to Congress and to MFUA. If carried out, each data source should be identified and described, including a list of all available data elements. In addition, for each source, an estimate of the completeness of coverage for Persian Gulf veterans and other Gulf-era veterans should be made. Issues related to confidentiality or other issues of access to the records also should be covered in the reports. In addition, updates of relevant ongoing studies should be made available to MFUA.

CONCLUSIONS

A good start has been made on all facets of the registry complex. Changes made at this stage could improve the usefulness of the information gathered in the VA examination registry and lay a better foundation for co ordination among the pieces of the registry complex once they are complete. Specific OTA conclusions include the following:

1. VA should focus immediately on revising the examination protocol.
2. Terminology used by VA and DoD should be brought into conformity, where appropriate.
3. A joint oversight body for the VA and DoD registries and their related activities should be appointed, which would enhance existing coordination and cooperation.
4. Information on exposures and other experiences of Desert Shield/Desert Storm should be assembled by DoD in a qualitative history for the Persian Gulf theater of operations.
5. DoD and VA should assemble annotated inventories of all sources of relevant health and demographic data, other than the registries, for Persian Gulf veterans.

I hope this information is useful to the Committee. We will be happy to answer any questions you may have about our work in assessing the Persian Gulf registries.

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Honorable Ladies and Gentlemen of the House of Representatives. I want to thank you for the opportunity to speak at these proceedings.

Growing up I knew I could do anything I wanted, but the key was to find something worth doing. I thought I had found it, "a most noble endeavor" defending the Constitution. I enlisted in the Army in 1984, I was seventeen. I made Sergeant at eighteen and was commissioned a Lieutenant at nineteen. I was an Airborne Ranger Infantry Officer with a Combat Infantryman's Badge from Panama and Iraq by the age of twenty four. I had expected to be a Captain in months and a Colonel by thirty five, the country's money problems changed that course. I would have stayed with no pay but no one seemed to listen. I had thirty days to take my family back to where I came from. Unknown to me, I also carried a chemical wound sustained in Iraq. Gradually that wound began to take its toll. I will pause here and say this, I volunteered so I have to take what I get, however, my wound has caused identical wounds in my wife, Kelli, and my son, Alex. They did not volunteer, they did not take my oath, they have been drafted against their will to fight the enemy. They fight untrained, they fight unarmed and they will never receive the purple heart they earned and deserve. Before I get carried away complaining, let me outline the **PROBLEM and your SOLUTION.**

We fought a war and a lot more people got wounded than we initially thought. The majority of the wounded feel they must conceal their wounds or they will be eliminated from the service - **THAT IS A PROBLEM.** Additionally many of the Gulf War vets have all ready been separated from the service, the only recourse for these families is to seek recourse from the V.A. medical centers. In 1865, Abraham Lincoln charged the V.A. "To bind up the nations wounds, to care for him who shall have born the battle, and for his widow and his orphan." Unfortunately, the V.A. fails to accomplish this clearly defined mission. The V.A. is choked into an action by regulation and restriction, so what do we do for our wounded who are afraid to seek care, or have V.A. care for themselves and not their family? The answer must provide for entire families and should also make it easier for those who must create a medical solution. One of the major obstacles to the medical solution is the length of time it will take to study, and that the true numbers of

wounded and dying are unknown. The solution must draw the wounded out of concealment, and provide for those to wounded to provide for their families while the research continues.

My families experience should provide you with a good example! My wife Kelli is 23, Shelby is 3, and Alexander is almost 10 months old. After the Gulf War, we had two miscarriages during 1992. One in January and the other in May, this nearly tore us apart and for this we sought counseling. In October, Alex nearly miscarried but the doctors managed to halt the delivery. My wife and I both developed red spots and began to collect a series of other symptoms. My symptoms also included itchy, painful, bull's-eye red spots that spread. I began to swell., my lips split open and bled, my eyes shut and my throat closed. An E.R. visit and steroids reduced the swelling. The spots lingered and fatigue continued over the year, it only took my family doctor a week to give up and refer me to the V.A." where they know about these things." I spent more than a year trying to get answers out of the North Chicago Medical Center, and even more symptoms have developed. Breathing problems, digestive problems, diarrhea, bleeding gums, hair loss, difficulty sleeping, mood swings and hearing problems.

Alexander had a March 7 due date, but he arrived on January 20th seven weeks early. His fight was tough from the start, in addition to our red spots, he had spinal meningitis, Strep B infection, cranial hemorrhage , and an immediate need for respiratory ventilators to survive. Initially the doctors said that he had less than 20% chance to survive. During his first three months, he encountered many reverses and on three separate occasions we were called to spend our last hours with him. The doctors had to cut out the top part of his left lung and insert in a dozen chest tubes, one or two every time a lung would collapse,. our son was fed by a tube in his nose, and was off and on ventilators five times. He generated twelve hundred pages of medical records. Alex had a half million dollars worth of medical insurance, it was entirely gone within ninety days. Alex's prognosis includes vision and hearing problems, growth retardation, baby emphysema, and cerebral palsy. He is requiring physical therapy, oxygen, suctioning, breathing treatments and two monitors. He has been approved for SSI disability but I had to personally beg his doctors to continue to treat him after his regular insurance was gone. I know that he never would have survived in a military or V.A. medical facility.

Alexander stabilized, due in large part to my hero wife who trained herself to be his doctor, nurse, respiratory therapist, physical therapist, ect. ect. and we began to care for him in our home., but Kelli and I started to get worse and worse. We made the decision that I would go into the V.A. alone and that we would not leave until we had an answer. I can not get medical care for my wife and my son but I tried to get the V.A. to give me the key to a medical resolution of at least our

chemical wounds, I also want to help all of the Gulf War vets that have been calling me to say that their family is wounded but they are counting on me to get the solution in place.

Currently I am in the Houston V.A. Medical Center, but it has taken a week to get the truth. At this time, there is absolutely nothing that can be done for us., other than to comfort us, because there has not been enough research. In order to make the wounded available and care for all members of the wounded families, I recommend that all those suffering Persian Gulf Syndrome be put on active duty, and made comfortable, and available to research a solution. It will also ensure that their jobs are protected by law.

We are only asking for medical attention for the wounded. We are only asking that research be conducted. We are only asking for the same level of care that the United States is giving Iraq X-POWs' s and their families, two hundred of which are seeking asylum in the county next to mine. This would get us off public-aid, and prevent many V.A. home loans from going into default, because ultimately if we can not see our self clear to help our wounded veteran families, many reduced to public aid, how could we ever offer this level of care to the entire United States under the "health care reform."

AIRBORNE RANGERS LEAD THE WAY!!!!

Troy and Kelli Albuck

Timothy James Striley

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November 16, 1993

My name is Timothy Striley and I am a veteran of Operation Desert Shield, not Operation Desert Storm. I deployed to Saudi Arabia on the 14th day of September, 1990 with the 101st Airborne Division (Air Assault) of Fort Campbell, Kentucky. Upon arrival, my fellow soldiers and I were detailed to set up tents, a tough job in the hard earth of King Fahad International Airport. After two days of doing this, I suffered a second-degree sun-burn on my face, neck, and arms. This healed up over the course of the following days and everything seemed to be okay. Weeks passed before, during guard duty one day, my neck began to burn. When I reached around to the back of my neck, my hand returned covered in puss and blood. After finishing my guard shift, I immediately went to our prescribed medical unit seeking relief. The doctor there prescribed topical creams to combat the unknown rash. Over the course of the next days, the rash spread to my face and scalp. The clinic doctor this time prescribed a different regime of topical creams. Again there was no relief. I returned later with the same "lesions" that were described as "weeping and crusted," and this time experienced gastro-intestinal discomforts, including a fever, vomiting, and diarrhea. This time there were new medications for the intestinal problems, and more creams for the rash. By this time, the sores were also on my arms and hands.

The internal problems seemed to go away and I was then sent to other medical units for evaluation. This continued until I was given a shaving profile (1/4" of growth), again having no relief and I was put on a regime of the oral steroid, Prednisone. On November 21st, 1990 an explosion rocked our area of operations, which was later determined to have been caused by the mis-fire of a Hellfire missile accidently launched into an Air Force ammunition dump. The sores worsened, and out of genuine concern, my commander, LTC John M. Carden, stepped in to help and had me evaluated by the division Surgeon General, COL Kimes. COL Kimes ordered that I be evacuated to the Navy's 5th. Fleet Hospital in Al Jubail.

It was there that I first showed any sign of improvement during Operation Desert Shield. I stayed in the hospital there for one week under sterile conditions and a large dose of antibiotics. Within days of my return to King Fahad International Airport, the sores again re-appeared. The doctors again attempted treatment.

During this time (December and January of 1990), my unit's gas alarms went off frequently. Each time, we immediately donned our protective masks, and occasionally our entire protective suit. On one particular occasion, we were ordered to seek cover in underground tunnels. Each of these occurrences we were told that scud launches had been detected. Each time, we were told "All clear" and the missiles were said to have either been exploded prior to arrival over the Saudi Arabian border, or to have been false alarms. On one of these occasions, a civilian airliner landed with new arrivals. All persons aboard ran from the aircraft and into Air Force bunkers, including the civilian employees.

At this time it was evident that my protective mask would not seal correctly due to the beard growth. Senator Tom Harkin (D-Iowa) stepped in and inquired about my health. Senator Harkin was told that I COULD still seal a protective mask and that we were not expecting Iraq to use thier chemical or biological weapons. It was at this point that his continuing inquiry finally led to my evacuation from the Persain Gulf theatre of operations. I packed my gear and orders were cut. My company commander (MAJ. James Budney) told me that he would send my medical records later. On or about the 15th of January, 1991, I was flown back to Fort Campbell, Kentucky. My records from Saudi Arabia did not return from the gulf and when asked after the war, my commander said they were either lost or destroyed during the war.

I immediately began seeing a dermatologist at Blanchfield Army Hospital at Fort Campbell (LTC Marlise Collins, MD). She ran allergy tests and determined I had excema (Which she concluded was a hereditary condition with my parents and siblings suffering the same disorder). She later sent me to Fort Gordon, Georgia for a second opinion and attempted to have me sent back to Saudi Arabia with a shaving profile, white gloves, and large amounts of special shampoos and steroid creams. She also reported that I should be discharged under "False enlistment" charges (for not telling about my so-called illness at the time of my enlistment.). No other members of my family have excema. My rear detachment commander elected to keep me in Fort Campbell as an able-bodied soldier needed for his mission.

As time progressed the sores came and went and new symptoms arose. I developed rectal bleeding, nausea, vomiting, problems with my knees, dehydration, and a noticeable drop in my energy level. In May of 1991 my wife, then fiance, suffered a miscarriage caused by a "Strange infection that seemed like a venereal disease, but tested negative for everything." I continued seeking medical help even after my unit returned from Operation Desert Storm. Members of my chain-of-command started calling me a hypocondriac and malingerer, which quickly led to problems. Shortly before my normal date of discharge (ETS), I was given an article 15 and reduced in rank to PFC (E-3). The harassment continued, I was barred from re-enlistment, and on August 30th, 1991, I was honorably discharged. At this time, I immediately filed a VA claim

for service connected disability, which I was later awarded, of 10% for excema. The problems persisted.In September of 1991, my wife again suffered a miscarriage from the same undiagnosed infection.

I learned of, and joined, a support network called the Military Family Support Network, out of Washington, D.C. and learned others were suffering the same symptoms. On January 16th of 1991, I came to Washington for the first time to speak at a press conferance pertaining to the "Gulf War Syndrome." During this visit I was seen at Walter Reed Army Medical Center (Infectious Disease) for Leishmaniasis blood tests and evaluation, which later came back reading "On the low end of the positive side." I was referred to my closest VA hospital for a confirmation bone marrow test. (This test was performed later, after getting "Into the system," at Iowa City VA medical center, Iowa City, Iowa. Result=Negative) Shortly after this test, my medical records became missing and I became frustrated with "The system!"

Months passed and I began seeing civilian doctors. The symptoms continued and new ones arose, including chest pain, dizziness, headaches, short-term memory loss, fevers, night sweats, and photo-sensitivity. I was given numerous medications and went through numerous tests with one result: Pericarditis. On August 25th, 1992 my wife gave birth to a "Healthy" baby girl. Six weeks later she (my wife) hemorrhaged, was rushed to emergency surgery, and again the doctors (civilian doctors) found a "Strange infection," they thought "Was a venereal disease, but which tested negative to all known venereal diseases."

During the summer of 1993 I learned about the Gulf War Registry (through the support network) and then went back to the VA. During my registry physical, my doctor found my prostate was enlarged and I was "Dropping" white blood cells and cell tissue into my urine, which resulted in a referral to the Urology clinic. Under the care of Dr. Andre Godet, I was subjected to an IVP and ultrasound which located a large growth on my right kidney. I was then put on antibiotics and scheduled for a CT scan, which confirmed a cyst over 50% of the kidney. I again was put on Antibiotics and scheduled for a return visit, later resulting in a confirmation that the cyst would not respond to treatment and actually grew during the course of medication. A biopsy was ordered, and in September (1993) it was completed. The fluid contained within the cyst was found to by dark brown and tested negative for: Leishmaniasis, Tuberculosis, Cancer, parasites, and viral infection. On a return visit, Dr. Godet and Dr. Andreoni (Infecticus Disease) confided in me that they did not know what was causing my problems, it was not "In my head," and that in the near future part or all of my kidney would have to be removed. The next consultation was set for January 10th of 1994, allowing time for the answers to be "Found" before going to the extremes.

More recently, I have also suffered from "Bursitis," a condition that makes my knees swell. This condition is usually found in someone much older and now limits my walking and standing (which makes the swelling occur). When this condition is at it's worst, I must use a cane to walk. With all of this, my employer finally had to take a stand and had to re-negotiate my employment. To date, I have not been allowed to return to work because of the problems these new conditions cause. Not only are my employers worried about my health and welfare, but due to the lack of a diagnosis and the seriousness of my condition, they are also worried about this condition being contagious. This I can understand, as my wife is showing some of the same symptoms, namely: chronic fatigue and headaches.

The symptoms I am having seem to coincide with those of other Gulf War veterans and I was not even in the Persian Gulf theatre during Operation Desert Storm. These conditions are very serious and the outlook into my future seem very grim. I am now (seemingly) unemployed due to this condition, my bills are going unpaid, my credit is destroyed, my families health is deteriorating, and my world seems to be crumbling before my eyes. I am 24 years old, my wife 29, my child only 14 months old. I am days away from being homeless, my pride has been destroyed by having to ask for public assistance (welfare, food stamps), and I am scared. At the same time, I am searching for the answers to save my life and the lives of others. We need help!

I am also concerned that this condition seems to be contagious. When we returned home from the gulf a ban was put on donations of gulf veterans' blood due to the possibility of spreading Leishmaniasis. On January 1st of this year (1993) the ban was lifted and gulf veterans are again donating blood. I believe we should again be banned from giving blood in light of the new evidence that is coming forward.

I have learned about the research being done by Dr. Edward Hyman and I have had urine samples screened by him, testing positive for what he has found in other Persian Gulf veterans. I can only speculate about the cause of this illness, but the theory I find most probable is the possibility of biological contamination. I find it hard to believe that Iraq would use it's weapons of mass destruction on Iran and it's own people (the Kurdish), but not against an enormous coalition military force. Certainly, it would (biological warfare such as this) be the work of a mad-man with no concern for human life. Saddam Hussein deffinately fits the bill and with no way known to even detect biological agents, I cannot see how this theory can be denied. It is likewise possible that Iraq delivered this agent late in 1990, prior to the beginning of hostilities.

The veterans of the gulf war are not hypocondriacs and we are not out to embarrass the United States Government, we are simply pleading for help! I come from a long line of veterans on both sides of my family, my father a career Navy man. Over the years of patriotic service, our

family has never experienced anything of the nature we are experiencing now. Even though I was never a perfect soldier, to this day I do not regret my service in America's armed forces. I am a proud American and I believe in service to my country! However, at this point in my life, I cannot endorse the military to any other person (namely my three younger brothers). I challenge you to change my new-found opinion! Help us to find the answers to what is happening to us (the gulf war vets), save our lives and give us the chance at life that we deserve! If we are contagious, treat those we have exposed and stop us from exposing anyone else! Don't make the men and women that less than three years ago were America's heroes die and become America's killers (by spreading this disease)! Learn from this, teach it, and never let it happen again!

Timothy J. Striley

Timothy J. Striley

STATEMENT OF

DENNIS CULLINAN, DEPUTY DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE OF VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

VA AND DOD RESPONSIVENESS TO PERSIAN GULF WAR VETERANS

WASHINGTON, D.C. NOVEMBER 16, 1993

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.2 million men and women of the Veterans of Foreign Wars of the United States, I wish to express our deep appreciation for conducting today's most important oversight hearing and for including the Veterans of Foreign Wars in this forum. The VFW is absolutely adamant that those who served in the Persian Gulf war not suffer the same neglect and denial with respect to the government's properly caring for their special service-connected disabilities as did their brother veterans of the Vietnam war. It is now manifestly evident that many veterans who served in the Persian Gulf war are suffering from an array of problems and disabilities that are the result of their service in that war. Regardless of how many forms the "Persian Gulf Syndrome" may assume, or whether or not the exact cause is ever precisely determined, the VFW insists that this nation honor its moral and statutory obligation to her combat service-disabled. Veterans suffering from the Persian Gulf Syndrome must be afforded all of the care, compensation and compassion a grateful nation has to offer.

That Persian Gulf veterans are now suffering from a multitude of disabilities attributable to their service in that conflict is obvious. What is not so clear, unfortunately, is the cause. There is now a growing body of evidence suggesting that a number of United States troops assigned to the Persian Gulf during the Gulf war were subjected to some sort of chemical/biological warfare attack or exposure due to an indus-

trial accident or allied bombing of Iraqi munition sites. But, while the cause remains uncertain, it is clear that a large number of Gulf veterans are suffering from a myriad of ill health symptoms including but not limited to: muscle and joint pain, loss of memory, heart and intestinal problems, fatigue and running noses, urinary urgency, rashes and sores, diarrhea, and bodily twitching. Such symptoms are often associated with exposure to toxic chemical agents and the VFW is absolutely incensed that until just this past Wednesday DOD denied the possibility of such exposure outright. Fortunately, thanks to growing public awareness and scrutiny, DOD has had to reverse itself and acknowledge what many Persian Gulf veterans and a contingent of Czechoslovakia's Chemical and Biological Warfare experts have maintained all along: the Persian Gulf Syndrome or "Mystery Illness" is the result of exposure to toxic chemical agents. It is our view that DOD recalcitrance in this matter is an absolute outrage and an affront to the sacrifice and service of all of America's veterans.

Other "theories" abound as to what exactly is causing Gulf War veterans to exhibit the symptoms of the so-called "mystery illness." They include: smoke inhalation due to burning Kuwaiti oil wells, radiation from rounds fired from allied armored vehicles (known as "uranium depletion") and exposure to parasitic diseases endemic to the Persian Gulf, such as leishmaniasis. The tests done at VA for the Health Registry revolve around a basic physical examination with emphasis placed on these afflictions. A somewhat more popular theory as to the cause of the "mystery illness" is something known as "multiple chemical sensitivity," which DOD has acknowledged and pursued. Multiple chemical sensitivity is the development of multiple and diverse symptoms due to exposure to chemicals, but not necessarily chemical warfare agents. It involves reactions to levels of chemicals well tolerated by most people. This reaction can be due to exposure to chemicals found in: fuels, propellants, paints and preservatives, solvents, lubricants, pesticides, herbicides, combustion pro-

ducts, repellents, and chemical warfare agents. There are even some investigators who attribute multiple chemical sensitivity to underlying psychological problems including depression, Page psychological conditions, stress and even to an inappropriate belief that chemicals are causing symptoms. However, these investigators have not ruled out actual chemical exposure as the cause.

The real issue here, however, is not so much whether Iraq used chemical or biological weapons on U.S. troops during the Gulf War, although that is a serious matter and deserves careful attention. The main issue that concerns the VFW is that numerous veterans of the Gulf War are suffering from some type of ailment or ailments due to their service in the Gulf and, mirroring the Vietnam agent orange experience, there would seem to be a perceptible attempt by some to disregard and even cover up the problem. Bottom line: Persian Gulf veterans need and deserve help and they need and deserve it today.

Mr. Chairman, this concludes my statement. Once again, I thank you for conducting today's most important oversight activity and would be happy to respond to any questions you may have.

Statement of

Kimo S. Hollingsworth, Assistant Director

National Legislative Commission

The American Legion

Before the

Committee on Veterans Affairs

Subcommittee on Oversight and Investigation

United States House of Representatives

November 16, 1993

Mr. Chairman, The American Legion appreciates this opportunity to testify concerning health issues related to service in the Persian Gulf. We appreciate your leadership for holding a hearing on such an emotional and sensitive issue. The Legion would also like to express its appreciation to Congressman Kennedy and his staff for holding a special hearing for Persian Gulf veterans on November 9, 1993. It is this type of aggressive and persistent leadership that will help Persian Gulf veterans and government health care officials to learn more about possible sources of health problems they now face.

On June 9, 1993 The American Legion and others testified before this Subcommittee on this very issue. As a result of that hearing, legislation (H.R. 2535) was introduced and passed the House that would allow Persian Gulf veterans to receive priority health care at VA medical facilities. The Legion sincerely appreciates the actions and commitment of the members of this Veterans Affairs Committee in support of H.R. 2535. However, further action on this measure is still pending in the Senate.

Mr. Chairman, since that hearing the number of veterans listed on the VA's Persian Gulf Registry has nearly tripled. More and more veterans, including many on active duty, have come forth to admit health problems that they believe to have developed as a result of their service

in the Persian Gulf. The American Legion is pleased to hear the Department of Defense finally acknowledge that there are "hundreds, possibly thousands" of sick active duty personnel. This confirms previous suspicions that the medical problems were not only being experienced by Reservist and National Guard personnel.

The Legion is pleased with the pro-active position taken by the Secretary for Veterans Affairs concerning chemical sensitivity and chemical/biological warfare. The Legion would encourage the Department of Defense to follow suit.

Legion representatives attended the DoD press conference on November 10, 1993 and were terribly disappointed with the explanation of the chemical detection reports by the Czech chemical teams. Until recently, DoD adamantly denied any reports of exposure to chemical or biological agents in the Persian Gulf. The Legion felt the press conference produced half-truths and understatements as to the degree of exposure of Coalition Forces to chemical agents. The issue of possible exposure to biological agents was never addressed. The practice of mixing chemical and biological agents is a known delivery techinque. With the presence of chemicals now being acknowledged by DoD, the possible presence of biological agents must now be addressed.

Mr. Chairman, based on research and practical experience, I know that the presence of radiation and chemical agents can be readily detected by personnel in a combat environment; however, biological agents can only be detected by trained laboratory personnel. This inability of the individual to detect a biological attack is perhaps the greatest threat to personal safety and the ability to fight. Delays experienced before the onset of symptoms and

the time required to identify specific agents further complicates the problem of detection and protection by individuals in the theatre of operation.

Mr. Chairman, in the Marine Corps Institute's Command and Staff College Nonresident Program on Nuclear and Chemical Operations, Section V specifically discusses Biological Agents. It says: "Biological agents can't be detected by the human senses. A person could become a casualty before he is aware that he has been exposed to a biological agent. An aerosol or mist of biological agent is borne in the air. It moves with the air currents and can enter buildings and fortifications. These agents can silently and effectively attack man, animals, plants and in some cases, material."

"It is likely that agents will be used in combinations so that the disease symptoms will confuse diagnosis and interfere with proper treatment." The symptoms reported by Persian Gulf War veterans have clearly confused most doctors and defied almost all treatments.

Additionally, the text states: "Different antipersonnel agents require varying periods of time before they take effect, and the periods of time for which they will incapacitate a person also vary."

"The micro-organisms of possible use in warfare are found in four naturally occurring groups - the fungi, bacteria, rickettsiae and viruses."

Fungi - "They range from a single cell, such as yeast, to multicellular forms, such as mushrooms and puffballs."

Bacteria - "They may occur in varying shapes, such as rods, spheres, and spirals, but are all one-celled plants."

I want to remind this Subcommittee of the testimony presented by Dr. Edward Hyman of New Orleans last June. To date, Dr. Hyman has successfully treated nine Persian Gulf War veterans and three of their spouses. His research has found that all twelve patients have had bacteria in the shapes of spheres present in their urine. He has also found elements of yeast, which would suggest a fungus.

Referring back to the Marine text, biological agents are normally dispensed in aerosol form: "In field trials, using harmless biological aerosols, area coverages of thousands of square miles have been accomplished. The aerosol particles were carried long distances by air currents."

Prior to the ground war, American and Allied aircraft extensively bombed the Iraqi chemical and biological factories, munitions storage facilities and propositioned ammunition stockpiles. As a Marine who participated in the Persian Gulf war from January through May, I give you first hand testimony that the winds blew predominately in a southerly direction.

Again, since there is presently no test to accurately determine if biological agents are present. Personnel are taught to look for dead animals or plants and to be alert for physical symptoms that are similar to those reported by Persian Gulf veterans who are now ill. Numerous reports acknowledged herds of dead animals in northern Saudi Arabia, Kuwait and southern Iraq.

In reviewing military health records of returning Persian Gulf veterans, The American Legion noticed a form (Southwest Asia Demobilization/Redeployment Medical Evalulation) used by health care providers that questioned personnel about possible exposure to enviornmental hazards,

specifically chemical or biological exposures. Many of the questions on that form perfectly match the symptoms being reported by the Persian Gulf War veterans. This form clearly indicates that DoD had anticipated these symptoms.

Mr. Chairman, The American Legion believes that the United States intelligence agencies are withholding valuable information that could play a critical role in finding the cause and cure for the medical problems faced by Persian Gulf veterans.

The American Legion continues to urge Congress, the VA and DoD to conduct a thorough epidemiological study of all Persian Gulf veterans. This study would provide the data base for further testing and evaluations. Time is critical.

Mr. Chairman, that concludes my testimony. Thank you.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Paul S. Egan
Executive Director

To The

House Veterans' Affairs Subcommittee on Oversight and Investigations

On

Persian Gulf Veterans Health Concerns

November 16, 1993

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Introduction

Mr. Chairman and members of the subcommittee, Vietnam Veterans of America (VVA) is pleased to have the opportunity to present testimony regarding the current plight of Persian Gulf War veterans. Under the circumstances, we take an opportunity to discuss a full range of issues concerning Desert Storm veterans that ultimately will bear on the claims for benefits these veterans will file in the future.

In order to explain the concern Vietnam Veterans of America holds for veterans of Desert Storm, we note that VVA pledged at our founding convention and continues to reaffirm the principle that "never again shall one generation of veterans abandon another". It is apparent from the difficulties Persian Gulf veterans experience in getting straight answers from the government that sent them to war, that their challenges in getting just compensation and treatment for the less obvious or latent war injuries are virtually identical to those faced by Vietnam veterans exposed to Agent Orange. To this end, we offer our support, knowledge and advocacy to the needs of our brother and sister Persian Gulf War veterans.

Possible Chemical Exposure -- Administration Lacks Cohesive Policy

Immediately following the Gulf War it appeared that the government was denying responsibility for mysterious illnesses many have experienced, blaming "stress" as the causer. This is particularly disturbing because of the struggle Vietnam veterans waged to get Post Traumatic Stress Disorder recognized as a legitimate mental health problem. Using PTSD as a "catch-all" condition seriously detracts from this hard won credibility, and denies these Persian Gulf veterans appropriate treatment for their physical maladies.

Some Department of Veterans Affairs (VA) and private sector doctors developed techniques of treating these veteran patients who seem to be experiencing diseases endemic to the region, multiple chemical sensitivity, conditions related to exposure to smoke from oil fires or depleted uranium, or possibly the administration of experimental vaccines and drugs to U.S. troops. Though neither the VA nor the Department of Defense (DOD) officially recognized any particular pattern among the veterans presenting themselves for care.

Recently reports from the Czechoslovakian government that low concentrations of chemical agents were detected during the Gulf War seem to support claims made by many veterans that American sensors also warned of dangerous conditions. Many who describe these events indicate that superior officers discounted the alarms, however, explaining them away as malfunctions. DOD still proclaims it has been unable to confirm the Czechoslovakian reports. And Secretary of Defense Les Aspin postponed a Congressional briefing on the issue because information was "inconclusive".

Secretary of Veterans Affairs Jesse Brown has announced that the VA will soon begin testing Persian Gulf vets for health problems that may be related to their exposure to chemical agents, as a result of the recent revelations. Symptoms include fatigue, headache, diarrhea, irritability, forgetfulness and weakness. Brown has also directed that exams provided earlier to those on the VA's Persian Gulf Registry be reviewed to determine if these individuals should be called back for neurological and other testing.

VA will also begin research on treatment modalities for these conditions. Earlier this month, VA announced that the National Academy of Sciences (NAS) has been contracted to do an independent review of possible environmentally related health effects of Persian Gulf service, similar to that NAS is doing on Agent Orange. VVA is encouraged by these steps, as it reflects an openness on the part of VA that was absent following the Vietnam War. It is troubling that coordination between VA and DOD seems to be faltering, however.

One must ask what information is being held back, when two top cabinet officials cannot agree on the problem, let alone the solution. VVA is very pleased by the actions taken by VA to address this new information. Although there have been concerns in the past that physician research on this issue has been suppressed by VA, as has been noted in news accounts of Dr.

Charles Jackson's diagnosis of a patient exposure to "chemical biological warfare" in the Tuskegee VAMC.

Our concern about the lack of a cohesive policy within the Administration, is that it most certainly is an indication that someone, somewhere is withholding information which could be very helpful in treating the health conditions experienced by these Persian Gulf veterans. Second, but not of lesser importance, is the fact that while Persian Gulf military personnel who have been discharged are able to access testing for chemical exposure through the VA, those who remain on active duty are being denied similar testing by DOD. Thousands who served in Operation Desert Storm are career military personnel who remain in the service. To get needed care, many would have to risk their career or go to great personal expense to secure private sector treatment for their Gulf War service-connected conditions.

Claims for Benefits

Military leadership promised VA would take care of veterans problems after discharge. The stark realization that the VA is not in the business of approving claims, but disproving claims leaves the veteran frustrated, angry and feeling betrayed by the nation he or she served. Those are the realities faced by veterans and their families, regardless of the claims of the Defense Department and the VA that this war produced no serious health problems.

Further, these agencies state that the government is doing all it can to correct those problems that it has identified. VVA would like for that to be true and, while it may be true in some very clear cut cases, such as wounds received in battle, it is not true in the case of illness and mental disorder. It would appear that the old adage of "show me the scar and I'll believe you are disabled" holds more weight than ever before. The veteran who is missing a limb as a result of a combat wound is more readily believable than a veteran who is suffering from rectal bleeding, dramatic weight loss, hair loss (which returns with complete loss of pigment), chronic diarrhea, debilitating fatigue, muscle and joint aches and on and on ad nauseam.

Desert Storm veterans face a more serious problem filing claims for benefits than most veterans. The recent DOD practice of not providing exit physicals to discharging veterans fails to alert discharging veterans of health problems they might not have previously noticed. Conversations with discharging Desert Storm veterans from Fort Dix, New Jersey indicate that the only medical exam they were given was an eye exam.

Persian Gulf Health Registry

Congress deserves significant credit for the establishment, in the Veterans Health Care Act of 1992, of the Persian Gulf Veterans Health Registry. This tool, listing every individual who served in the Persian Gulf theater of operations, will allow a valid and committed researcher to identify who was there and to have a data base for statistical analysis. The problem is, however, that statistical analysis can never substitute for an epidemiological study and, when combined with the Department of Veterans Affairs ten year contract with the NAS, will only provide statistical data about what has already occurred. Yet, even with these tools, veterans are already being denied claims because their medical records cannot be located or their military record fails to reflect their service in the Gulf.

While the VA has published the Persian Gulf Registry requirements, it is significant to note that Reservists and National Guard personnel are not being tracked through the VA system. This information was obtained through a Freedom of Information Act (FOIA) request.

Similarly, when Gulf veterans report to a general VA facility or to one of these designated care centers, there is at least some evidence to suggest a deliberate deemphasis of the seriousness of the symptoms reported.

The Problems Are Real, Not Imagined

VVA does not profess to be an expert in the field of epidemiology, nor do we profess to be medical experts. We do contend, however, that these veterans are worried about effects of exposure to environmental hazards to themselves and to their families. Many report that their wives have been suffering miscarriages, hair loss, kidney infections and rashes complete with lesions. They are both concerned and angered by the glib answers being given. Many are tired of being told that their symptoms are caused by chronic fatigue syndrome (CFS) or PTSD. We refuse to believe that all of these symptoms are in their heads.

These veterans are afraid of their deteriorating health. They are afraid of the economic disaster that they have already encountered by paying out of pocket for diagnosis and treatment that should have been provided by the VA. They are afraid that they cannot or will not be able to work and provide an income for their family. They are afraid that, even if allowed to work, they will not be able to secure medical coverage or life insurance for themselves and their families without paying exorbitant premiums or being eliminated from reimbursement for pre-existing conditions. For those who already possess medical coverage, they are slowly depleting their lifetime maximum benefits by filing claims against their insurance that should have been covered by the VA.

These concerns are not diminished in any way by the government's reliance upon specific scientists who, for years, seemed to think that Agent Orange was a soft drink. General Ronald R. Blanck, now the commander of Walter Reed Army Hospital and a member of the Persian Gulf Expert Scientific Panel appointed by VA Secretary Jesse Brown (VVA was not invited to serve on this panel), has been quoted as reporting that extensive evaluation at Walter Reed Army Medical Center and certain VA hospitals by the Reserve Component medical system and thorough epidemiological investigations have failed to show any commonalty of exposure or unifying diagnosis to explain a wide range of symptoms that have shown up among veterans since the Gulf War. If that is so, than one would be asked to accept that the diagnoses of CFS, Chrones Disease, Fibromyalgia and Alopecia given to many active duty personnel and veterans is simply coincidental and has nothing to do with their service in the Gulf War.

Independent Testing, Diagnosis and Treatment Is Needed

The burden of proving that their ailments are related to exposure to chemicals, depleted uranium, sand flies (parasitic infection), modified (untested) vaccines/inoculations and possible enemy chemical and bacteriological agents must not be allowed to rest on the shoulders of the veterans and their families. Their testing and diagnosis must also not be allowed to remain alone within the realm of the VA, the CDC, or the DOD. These agencies have historically shown a vested interest in the outcome of studies and the value of their research will forever be questioned by the veterans community. Some have an interest in denying responsibility while others are motivated by purely fiscal considerations and all are subject to political whims and direction.

What is necessary is a bold step, one that should have been taken long ago. Congress must act immediately to establish entirely independent testing, diagnostic and treatment facilities throughout this nation.

These facilities must be connected with universities or hospitals that specialize and are on the cutting edge of diagnosis and treatment of occupational illness (specifically chemical and radiation exposure), Multiple Chemical Sensitivity, cancer research and parasitic infection (see attached article on Multiple Chemical Sensitivity in Gulf veterans). These facilities must be allowed to operate without restriction and/or interference from the VA, DOD, or CDC. Their findings must be combined and compared and published openly, without prior review or comment by the aforementioned agencies. They must be allowed to confidentially examine, diagnose and treat not only veterans, but active duty military, National Guard and Reserve veterans of Desert Storm and Shield. They must be allowed to examine, diagnose and treat family members of veterans including children conceived after Desert Storm and who report adverse health affects. Finally, their diagnosis must be accepted, without challenge by the VA.

As part of this proposal, we strongly recommend the establishment of professional teams of specialists who can travel to Kuwait and conduct medical status surveys of the indigenous population, similar to the independent study on Agent Orange that we strongly advocate be conducted in Vietnam. In this way, a better picture can be ascertained of what symptoms and medical conditions are common to both our veterans and the local population.

We realize that the cost of such a project could be great. Consider, however, the cost to each individual veteran and their family if we do not undertake such a project. Consider the cost to this nation in the knowledge that our youth has been sent to war and will be abandoned upon their return simply because the cost of legitimate diagnosis and treatment is too great for this nation to bear.

Conclusion

Active duty military personnel report, in anonymity, that their concerns are not being legitimately handled. So great is their fear of reprisal, that their wives are taking up their fight in order to preserve their military career. Active duty military personnel and discharging veterans report that the documentation that is so desperately needed to support future claims presented in the VA is not being appropriately assembled.

Congress must take on the responsibility of securing information with regard to the health, treatment and documentation of the sick active duty military personnel and their families. This must be done with protection of their confidentiality by Congress so that their voice may be heard without fear of reprisal. The failure of the military to accurately report, document, diagnose and treat their ailments will result in more veterans being "dumped" into the VA system, who will have nothing to look forward to but delayed and denied claims while they bear the burden of proof that their illness is a result of military service.

These items are not new to those of us who have real concern for veterans and active duty military personnel. It has been exemplified in the DOD and VA treatment of those who were involved in nuclear testing, testing of LSD and other drugs, Mustard Gas testing and exposure during WWII, Agent Orange exposure and now, the "Desert Storm Syndrome."

Mr. Chairman, this concludes our testimony. Given the short preparation time for this hearing, we reserve the right to submit additional comments at a later date.

Statement of Myra B. Shayevitz, M.D.,FACP, Veterans Affairs Medical Center, Northampton, MA 01060 November 16,1993.

In 1989, I considered myself an experienced specialist in Internal Medicine and Pulmonary Disease who had heard of every entity in my field, when I became ill with a bewildering and completely disabling array of symptoms. Unable to help myself, I went from doctor to doctor until seeking help from the State University of New York Health Science Center at Syracuse, I learned that I suffered from Multiple Chemical Sensitivity Syndrome. After four months of treatment which included strict environmental controls, special diet and nutritional supplements, exercise, psychological support and education in self protection techniques, I was able once again to function productively and return to work. At the beginning of this illness, I could not read for even 10 minutes without becoming confused. After four months, I was able to successfully complete an advanced examination in Geriatrics.

About one year ago, I was casually reading about the mysterious "Gulf War Syndrome" and there before me were symptoms I recognized all too well. I immediately volunteered to become the Environmental Physician at our medical center and since that time have examined and treated over 25 veterans of the Desert Storm Operation. I have received calls for help from veterans and from those on active duty from California to Alaska.

What is the Multiple Chemical Sensitivity syndrome (MCS)? MCS has been defined as an acquired disorder characterized by recurrent symptoms referable to multiple organs and body systems occurring as a result of exposure to many chemically unrelated compounds but most frequently to petrochemical and or pesticide exposure. A clinically useful theoretical model holds that we are all individuals and that MCS may occur when the total tolerable biological, psychological and chemical load of the individual sufferer has been exceeded.The majority of cases begin with a combination of stress and a petrochemical/ pesticide exposure. One may postulate, therefore, that the stress of the Desert Storm conflict accompanied by the petrochemical /pesticide and possibly low level toxic chemical gas exposure may well have resulted in MCS in susceptible individuals. In fact, it is well known that many chemically sensitive patients experience severe symptoms upon exposure to diesel fumes. [1]Another important feature of MCS is that although the syndrome may arise from an acute trauma or event, subsequent symptoms are "triggered" by multiple very low levels of unrelated chemicals in common usage. The triggers become so ubiquitous and the symptoms so frequently incapacitating and difficult to contend with that self imposed isolation from society may result.

MCS is not limited to veterans of desert storm. The National Research Council estimates that up to 15% of the US population may suffer from MCS. MCS patients are frequent visitors to occupational health clinics and the diagnosis and treatment of MCS is listed by MassachusettsGeneral Hospital,Emory University School of Public Health, Environmental and Occupational Health Clinical Center at U.M.D.N.J, Robert Wood Johnson Medical School, Yale and Johns Hopkins (among other prestigious university clinics) in the directory of the Association of Occupational and Environmental Clinics. [2] and described by the brilliant researcher at M.I.T. Dr. Nicholas Ashford.

There are four groups of people among whom chemical sensitivity has been described:

1 **Table 1.** [3] Chemically Sensitive Groups

Group	*Nature of Exposure*	*Demographics*
Industrial workers	Acute and chronic exposure to industrial chemicals	Primarily males; blue collar; 20 to 65 years old
Tight-building occupants	Off-gassing from construction materials, office equipment or supplies; tobacco smoke; inadequate ventilation	Females more than males; white-collar office workers and professionals; 20 to 65 years old; schoolchildren
Contaminated communities	Toxic waste sites, aerial pesticide spraying, ground water contamination, air contamination by nearby industry and other community exposures	All ages, male and female; children or infants may be affected first or most; pregnant women with possible effects on fetuses; middle to lower class
Individuals	Heterogeneous; indoor air (domestic), consumer products, drugs, and pesticides	70–80% females; 50% 30 to 50 years old (Johnson and Rea 1989); white, middle to upper middle class and professionals

[1]Ashford,N,.A., and Miller, C.S. 1991 Chemical Exposures: Low Levels and High Stakes. New York: Van Nostrand Reinhold.

[2]Association of Occupational and Environmental Clinics 1010 Vermont Street, NW, Suite 513 Washington, DC 20005

[3]Ashford, N.A., and Miller, C.S. Multiple Chemical Sensitivities Addendum to Biologic markers in Immuntoxicology Naional Research Council National Academy Press Washigton, D.C. 1992

Could we now add a new group,to this list: Veterans of Desert Storm ?

Here are the textbook symptoms of MCS syndrome :Table 2.[4]

Symptom	*Percentage of Patients (N = 70) (no control group reported)*
Fatigue	94%
Food sensitivities	91
Gastrointestinal symptoms	63
Headache	50
Arthralgias	47
Drowsiness	37
Myalgias	36
Nervous tension	34
Nasal symptoms	34
Depression	30
Difficulty concentrating	27
Irritability	20
Confusion	17
Hives	16
Insomnia	11
Aching in chest	10
Fever	10
Eczema	10
Tachycardia	10

Here are symptoms of our veterans supplied to me by Dr. Han Kang epidemiologist for Veterans Affairs Central Office: **Table 3.**

TEN MOST FREQUENT COMPLAINTS AMONG 1404 VETERANS AND 145 WOMEN VETERANS ON THE PERSIAN GULF REGISTRY

COMPLAINTS	ALL VETERANS		WOMEN VETERANS	
	FREQUENCY	PERCENT	FREQUENCY	PERCENT
FATIGUE	191	13.6	31	21.4
SKIN RASH	188	13.4	21	14.5
HEADACHE	180	12.8	28	19.3
LOSS OF MEMORY	167	11.9	20	13.8
MUSCLE, JOINT PAIN	162	11.5	10	6.9
SHORTNESS OF BREATH	107	7.6	9	6.2
COUGH	70	5.0	11	7.6
DIARRHEA	63	4.5	7	4.8
CHEST PAIN	48	3.4	2	1.3
NO COMPLAINT	279	19.9	20	13.8

The Desert Storm veterans may not have MCS, but they do have identical symptoms to those with that disorder.

Did our veterans have chemical/pesticide exposures ? The following exposures are some of those compiled by individual interviews with hundreds of ill gulf war veterans

[4]Adapted from Rowe, A.H. et al From Bell, Iris, M.D.Phd, Clinical Ecology 1982 Common Knowledge Press

3 Nov16,1993 Statement of Myra B. Shayevitz, M.D., FACP
Veterans Affairs Medical Center, Northampton, MA 01060

Table4 [5]

1.Heaters in work and sleeping areas fueled with diesel (or Morgas blend)
2.Fuel spills and sprays on body parts
3.Oily clothing from oil, fire and smoke
4.Contact with ground soaked with fuel oil used for dust control
5. Fuel in shower water
6.Diesel exhaust from trucks or tanks in unventilated ship holds
7.Diesel heaters in tracked vehicles
8.Fumes from burning human waste with gasoline or diesel fuel
9 Pesticide fogging
10 Work in toxic land fill
11.Fumes while refueling vehicles
12.Petrochemicals in the water supply from desalinization system
13. Exhaust from airplanes and tracked vehicles
14 Fumes from freshly painted vehicles and storage containers
15.Chemicals used in the cleaning and maintenance of weapons
16.Fumes and smoke from the oil well fires

Almost 100% of the veterans in the environmental clinic at VAMC Northampton suffer from three disabling symptoms: Fatigue, problems with memory and concentration and depression.Many are unable to work, have little to no funds and many have little to no social support system. At our medical center there is no budget for special testing, organic rotation diet, air purifiers protective masks and nutritional supplements. There is insufficient staff available for patient education, psychological support, exercise training, nutritional counseling, psychological testing investigation of family and occupational problems and vocational rehabilitation, nor is there any chemically clean area for patient examination.When I ask a veteran to exercise vigorously (one of the treatments for MCS) I frequently find their shoes to be full of holes. A few weeks ago I spent a great deal of time describing a special diet that I thought would help, only to have the veteran say to me," Dr. Shayevitz, I'm so poor that you're lucky I have any food to eat". The time which I can spend with these patients is limited to only a few hours per week because of my other duties, as Director of the Cardio-Pulmonary Lab, Geriatric Evaluation Unit, Pulmonary Evaluation and Rehabilitation programs.

Finally, I want to discuss the attempted distinction being made between various forms of chemically induced illness that are being proposed as causative in the Gulf War Veterans. These include actual poisoning by known agents of chemical warfare including mustard and nerve gas whether deliberately or accidentally. Others ascribe symptoms to exposure to industrial chemicals as a result of bombing of plants. Yet others feel that an admixture of environmental toxic substances from oil wells and environmental factors unique to the Gulf region are producing this syndrome. **I strongly encourage continued research into all of these possibilities, however, it seems to me the common denominator is the symptoms of this illness itself which clearly approximates those of the clinical entity, Multiple Chemical Sensitivity Syndrome, about which much is already known and for which a rational and safe therapy exists. This treatment is most effective when accomplished early in the course of the disease. It would seem fool hardy to delay testing a treatment hypothesis while these patietns may still be helped. I support the need for further research, but I maintain that it is absolutely urgent for us to attempt a treatment plan.** MCS encompasses the physical as well as the emotional and cognitive, and because this syndrome is so devastating to the veteran and his/her family, we at Northampton VAMC have submitted a treatment proposal to VA Central Office using a medically sound biopsychosocial therapeutic approach.based on a thirty day hospital stay in a chemically clean ward, with an interdisciplinary team of specialists skilled in Environmental Medicine, Psychology, Psychiatry, Nutrition, Exercise Science ,Social Work and vocational rehabilitation who would follow these patients intensely for a minimum of one year.Comprehensive biological, and psychological testing will be an integral part of this plan and valuable information will result. Some of our patients are improving, and I have asked a few such patients to include statements for this record

[5]Haines, Richard, Major, Army Reserve, Indiana

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Veterans Affairs Medical Center, Northampton, MA 01060

This treatment plan now follows:

A BIOPSYCHOSOCIAL THERAPEUTIC APPROACH
FOR THE TREATMENT OF MULTIPLE CHEMICAL SENSITIVITY SYNDROME
IN VETERANS OF DESERT STORM
at
Department of Veterans Affairs Medical Center
Northampton, MA

The single most widely successful (and accepted) treatment of MCS is avoidance of stressors In this setting, deadaptation (withdrawal) occurs and healing commences. To that end, we at Northampton VAMC propose a 12 bed specially modified "Environmental Health Center" for the inpatient treatment of this syndrome. Our Environmental Health Center may not fully accomplish the "purity" of the experimental environmental unit, but we feel that we can minimize volatile organic chemicals in the air, food and water, and achieve an environmental "oasis" sufficient for deadaptation and subsequent healing to occur. Our program will provide a multidisciplinary team of specialists and employ a well designed treatment protocol which will guide patients through the clinical course of this process. We hope that our approach to the diagnosis and treatment of MCS will prove to be most practical and of value to other future programs.

Just as the patients must deadapt from the results of chemical exposures, they must adapt to the realities of coping with MCS. Therefore we will offer a concurrent program of strong psychological support, therapeutic nutritional support and patient education. Therapeutic exercise will also be a vital part of our agenda.

Northampton VAMC is located in a small New England college town away from major traffic but only one hour away from a major airport. There is a campus-like setting. VAMC Northampton has a thriving well equipped exercise training program and center specially geared to those with physical disabilities. (A good percentage of the patients exercise wearing oxygen). The staff of the designated unit is skilled in the rehabilitation of pulmonary patients, many of whom have similar problems and symptoms. They have seen first hand what can be accomplished with the necessary painstaking and meticulous approach required in these patients. The ultimate goal of our program will be to put the patient back in control of his/her life as an active participant in their own health care and to reduce or obviate symptoms so that the patient may return to productive functioning in society without further progression of the disease.

A. Criteria for Admission:

1. Case Definition for Purposes of Admission: Multiple chemical sensitivity syndrome may be defined as an acquired disorder characterized by multi system symptomatology referable to multiple chemical exposures which cannot be classified by existing criteria used in current medical practice for psychiatric or physical illness. The symptomatology occurs at exposure levels well below those thought to be harmful to the general population. The symptoms must be sufficiently incapacitating to justify admission to an inpatient treatment program. Incapacitation would be defined as an inability to work, and or such severe self imposed restrictions in life style and isolation from society that both patient and family members are adversely affected.
2. Candidate Population would give exposure based Persian Gulf veterans priority, but any veteran diagnosed as incapacitated from MCS would be accepted if space were available.
3. Referral Procedure: Referrals would be accepted from all VA facilities. The submitted budget does not allow for VAMC Northampton to pay for travel and referring VAMC would be responsible for round trip travel fees and arrangements. Self referrals will also be acceptable.

All candidates for referral will receive a Screening Packet containing a carefully crafted medical questionnaire as well as the Health Locus Questionnaire. The packet will also contain recommended laboratory and X Ray examinations aimed at excluding any other causes for the patient's symptomatology. In cases of self referral, we will look to environmental health physicians at the nearest VAMC to complete the screening requirements.

The screening packet will also provide the veteran with an overview of our program and will help to identify not only those veterans who are candidates for admission because of the severity of their symptoms, but also those individuals whose overriding consideration is to get well. The veterans will be informed that there will be no passes, no coffee , cigarettes or alcohol and no trips to the candy machine. Their diet and movement within the medical center will be under strict control so as to minimize their exposure to chemical stressors. They will be expected to study and to comply with all aspects of our treatment plan . The screening packet will make it clear that the patient's participation will be active rather than passive and no magic "quick fix" can be anticipated.

Upon receipt of the completed screening packet, a preadmission structured diagnostic interview will be conducted with the patient by the Program Director. In case of long distances, phone interviews will be acceptable. Next will come an interview in person or by speaker phone with the Screening Team consisting of the Nurse Practitioner, Psychologist,Social Worker and the Program Director. The final decision for admission to the Environmental Health Center will be by consensus.

B. Patient Evaluation:

1. Evaluation will be directed towards ;
   a. Choosing appropriate patients (screening out those who could not be expected to respond to the program or who would be disruptive to the program because of comorbid conditions)
   b. Identifying chemical stressors
   c. Delineating objective markers of the syndrome
   d. Determining test usefulness in diagnosis and treatment
   e. Gauging the degree of disability
   f. Measuring success or failure of the treatment plan

Because it is well known that no single objective test can be applied to this disorder,whenever possible, the chemically sensitive patient will be used as his/her own control in longitudinal testing.

2. Core Data Base:

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• medical history and physical examination
• social history including smoking, drug and alcohol use
• occupational history
• environmental and allergy history to include known sensitivities to foods, drugs and chemicals and other environmental allergens
• neurological evaluation with mental status exam
• Health Locus of Control Questionnaire
• MMPI
• Computerized review of systems
• Quality of Life Survey
• routine CBC and blood chemistries to include sed rate, eos count, liver function tests, ANA titres, thyroid function
• chest x ray

3. Specialized Evaluations:
• body composition and physical fitness survey including tests of strength and aerobic capacity
• comparative fitness testing based on patient's previous armed service physical fitness test on admission, at discharge from inpatient status , and at 6 months.
• Examples of specialized psychological testing depending on core survey:
  •Crisis Questionnaire
  •Appearance Concerns Questionnaire
  •Carroll Rating Scale for Depression
  •Shipley Scale (vocabulary)
  •Raven Progressive Matricies (over all cognitive ability)
  •Weschler Adult Intelligence Scale
  •Minnesota Clerical Test (attention span)
• EEG and Spect Scan whenever there is suggested impairment of neurological or psychological function
• nerve conduction studies whenever evidence suggests possibility of peripheral neuropathy
• pulmonary function testing for respiratory symptoms or complaints of fatigue especially on activity This will include sub maximal and maximal stress testing with peak flows and ear oximetry.
• immunotoxicology profile
• nasal and sinus examination for symptomatic patients
• Rast and Elisa- Act for cases of recalcitrant food sensitivity or failure of deadaptation

C. Treatment Plan:

1 Goals : The goal of our program will be the return of the patient to the pre-illness functional level with a minimum of chronic symptomatology and no need for repeat hospitalization within one year of the inpatient program. This will be defined by ability to once again successfully complete their respective services individualized physical fitness test (so far 100% of patients treated state that they are unable to do so) within six months of the program. Reaching goal will also be defined as normalization of any cognitive and memory deficits within one year.(See also endpoints for response)

2. Length of stay: is estimated at 30 days.

3. Medical Supervision: The Northampton Environmental Health Center treatment program will function as a matrix system. The program director will be responsible for the overall operation and direction of the treatment team. She will further be responsible for the necessary thorough environmental history and the development of any individualized aspects of the treatment program. She will guide the patient through the gamut of reactions which may occur during treatment ,aid in the recognition of environmental hazards unique to each patient and prescribe the necessary environmental controls and nutritional support. The program director will be responsible for the operation of the outpatient program to ensure continuity of care and patient follow- up. She will ensure that the data collected will be suitably collated and sent to VA Central Office.

4 Control of the Environment:
•100 % naturally ventilated filtered air
• Central water filter
• Drinking water will be bottled Spring Water
• Air purifiers in every room and in the hallways containing charcoal and high quality filters to remove odors as well as dust, pollen etc.
• Furniture will be metal
• Mattresses will be specially modified to obviate off gassing of flame retardant chemicals
• All bedding and bed clothes will be 100% cotton and will pre- treated to ensure removal of all sizing
• All room doors will have weather stripping to minimize the flow of unexpected odors into the room

• Janitorial supplies will all be non toxic fume emitting products
• All patients will be issued "safe" toiletries and these will be used by staff also
• All staff will be non smokers and will refrain from wearing scented toiletries. Their uniforms will be washed in the same manner as those of the patients. They will change into special "clean" uniforms at work
• All laundry will be washed on the unit by a laundry worker using products described on separate insert
• All traffic into the unit will be strictly controlled
• The industrial hygienist will check the air quality on a regular daily schedule

5 Nutritional Support: Approximately 80% of patients with MCS have food sensitivities. Foods, in fact, are composed of chemicals and foods in the same family are chemically similar to each other. Because of the spreading phenomenon described earlier, individuals may become progressively sensitive, and new food allergies frequently develop.

To further complicate matters, the masking effect may make it impossible to identify food incitants As is characteristic of the reactions to other chemicals in MCS, it is often only when foods are consumed after a period of abstinence that patients are then able to recognize their "triggers." For most patients, four days is sufficient time to accomplish both of these goals

Practitioners with the most experience with MCS (e.g. Rea National Research Council, MCS) consider a

properly balanced rotation diet to be an essential tool in the treatment of food sensitive patients and to minimize the development of new food allergies.
In a four day rotary diversified diet, one food from each food family is eaten once in every four days, although a wide variety of foods, consisting of high quality protein,complex carbohydrates and fats are eaten daily resulting in a nutritious and palatable diet. An alternate plan allows for the eating of different foods from the same food family on alternate days. Processed foods such as bacon are not included, nor are canned foods, and any foods known to be allergens to any individual patient are automatically excluded from the start. Some patients may need to be on more restrictive elimination diets. However, a four day rotation provides a practical solution for the majority, since patient

admissions will not be cohorted (rolling admissions) and patients may simply enter the diet rotation on admission day.
Our plan is to adapt the current VAMC Northampton diet, which is highly nutritious and diversified, to this plan. This will minimize added expense and maximize the ability of other similar future VA programs to utilize a rotation diet successfully. Samples of a four day Rotation Diet are enclosed. A specially trained dietician with a knowledge of food families will oversee this aspect of care.
Any vitamin or other nutritional supplements will be specially formulated for those with allergies,will not contain diluents, preservatives or chemical additives, and will be free of plant and animal allergens.
6. Psychological Support: A psychiatrist will be responsible for the overall assessment and treatment of any comorbid psychiatric disorders. The psychiatrist will be a member of the inter-disciplinary team working with the psychologist in the overall design and implementation of the psychological aspects of the treatment program and the development of the individualized treatment plan for each patient on the unit.
In the instance of comorbid conditions, the psychiatrist will be responsible for individual therapy.
The psychologist team member will be responsible for the administration and interpretation of all psychologically based tests in the core data base and for specialized psychological evaluations. The psychologist will provide individual therapy using such techniques as meditation, guided imagery and biofeedback with a specific emphasis on stress reduction procedures, anger management, social skills training and development of enhanced self esteem and improved coping strategies. The aim of these approaches will be to assist the patient to develop a sense of inner strength and the ability to "heal from within."
The psychologist will provide group therapy as well as family and couples therapy as dictated by patient needs.
The team social worker will also provide counseling in group therapy, family therapy and couples therapy in addition to his/her role as a member of the screening team. The social worker will also play an active role in the post hospitalization phase of treatment.
The psychologist will contribute to continuity of care by providing therapy on an outpatient basis both for individuals and for groups (see also section on long term planning).
The psychologist will also be responsible for post treatment psychological assessment . The psychologist will analyze this data to determine which tests are predictive of success and which tests or items have utility in discriminating MCS. He will be instrumental in designing the program evaluation measures and for the keeping of statistics.
Working with the program director and other members of the inter-disciplinary team, the psychologist will utilize data to help in the development of a relapse prevention treatment approach for patients suffering from MCS.
The team chaplain will hold regular sessions using meditations, reflection and music.
7. Education: (Avoiding the " porcelain village" possibility.)
Patients with MCS feel assaulted by the most common and mundane of items- a new car interior, fragrance emanating from the person sitting next to them in a movie, a new coat of paint, a freshly waxed store floor, deodorant in the rest room. Frightened and wounded, they retreat into social isolation. A vicious cycle ensues, for the less they do, the less they can do. Ignorant of self protection techniques, forays out of this isolation result in further damage and indeed some sufferers live their lives in porcelain lined dwellings. Merely removing the patient to an environmental unit and allowing them a degree of deadaptation may be insufficient to ensure that patients will not relapse and re-enter the highly restricted lifestyle for which they were admitted.
From the first day of admission to the Environmental Health Center at Northampton, the emphasis will be on the relief of symptoms and the return to pre-illness functioning. The patient will enter into an active partnership with the treatment team in an intense program of education. The nurse practitioner will act as program educator (as well as coordinator of the program and as right hand to the programdirector).
Upon entering the unit, the patient will be given an audio tape with accompanying printed material. This tape will describe MCS and introduce all the key concepts. The patient will be able to listen as frequently as he/she wishes. All other lectures will be completely self contained and no matter what day of the week the patient is admitted, he/she will be ready to listen to and understand the next lecture. The course will include detailed information on the nature of MCS, nutrition (including knowledge of food families, the safe addition of new foods, how to shop and cook), self protection and avoidance techniques, environmental controls in the home and at work, athletic training and a knowledge of the American with Disabilities Act and Federal Regulations for the support of disabled employees. Each lecture will be accompanied by written material so that by the time of discharge, the patient will have a virtual textbook of information which has been individualized for him/her.
Our education program will take the patients right into the community on guided trips where they can learn how to enjoy themselves while avoiding incitants. Damaging exposures however, are inevitable, but our patients will know exactly what to do to mitigate symptoms. Occupational and recreation therapists will teach patients conservation of energy techniques and provide patients with creative but non toxic projects and leisure activities. The psychologist will teach them useful techniques to handle stress, fear and despair. Each patient will receive an individualized exercise program.
In every aspect of our treatment plan, from avoidance techniques to the zealous pursuit of happiness, the patient will be given his own individualized self- directed plan. A thirty day treatment plan is just a start for a patient with MCS, but our aim will be to " propel" the patient into momentum for getting well rather than ever retreating into a porcelain village . Perhaps a motto for our program could be "Don't forget to live."
8. Exercise Training: There will be a varied daily program including strength training, aerobics and circuit

training supervised by an exercise scientist.
VAMC Northampton has a Parc Course, as well as well equipped Nautilus Exercise training center and gymnasium. Environmental controls will be employed in those areas as well as the ward.
9.Vocational Rehabilitation: Referrals will be made as required.
10. Longterm (post hospital) Planning:
• The program director, nutritionist, exercise therapist, psychiatrist social worker and psychologist will all hold outpatient office hours. Each member of the team will be able to refer patients to other team members.
If the director finds problems e.g. with diet, the patient will be referred to the team dietician.
• There will also be a bi-monthly support group run by the Psychologist and a similar group run by the team social worker.
• There will be regularly scheduled supervised outpatient exercise training sessions, three times a week.
• There will be psychological and physiological outpatient testing .

• Patients will be mailed a quality of life examination questionnaire every three months.
• For those patients living far afield from the medical center, scheduled telephone visits will be arranged. The social worker will provide a valuable link with other VAMC'S.

D. Workload Justification:
1. Occupancy rate : At an occupancy rate of 90%, 130 patients will be admitted per year. We would hope to see over 150 patients thus lowering the cost per patient from the estimate.
2. Estimated cost per case:
$13,468.11 for a 30-day inpatient stay and one year of follow up care including visits, support group, follow up testing, exercise program, medications, air purifier, and disposable dust-mist protective masks. Cost is exclusive of non recurring expenses.

E. Overall Program Evaluation:
Endpoints for success of this biopsychosocial program :
Psychological:
1. Improved functional behavior
2. Return of any cognitive deficits to normal
3. Subjective statement of improved quality of life on questionnaire
4 Improvement from pre-test psychological measures
Social:
1. Cessation of social isolation
2. Productive functioning in society
Physical:
1. Return to at least pre-illness physical fitness level
2. Decreased hospitalization by number and length of stay
3. Improved physiological measurements (see goals)
4. Normalization of any abnormal findings on neurological examinations
Immunological:
1. Normalization of any abnormal test results
Other:
1 Finding objective tests of this syndrome
2. Formulating a practical successful approach which can be of use at other VA medical centers

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CURRICULUM VITAE

MYRA B. SHAYEVITZ, M.D., FCCP,FACP
Veterans Affairs Medical Center
Northampton, MA 01060 TEL: 413-584-4040

College:
Barnard College, Columbia University, B.A., 1956

Postgraduate Education:
New York University College of Medicine, M.D., 1959
Dallas VAMC, Southwestern Medical School, Resident Physician Internal Medicine, 1959-1961
Baystate Medical Center, Springfield,MA:
Chief Resident in Medicine
Fellow, Pulmonary Laboratory 1961-1963

Appointments:
Consultant in Pulmonary Medicine to the Northampton VA Medical Center 1967- 1978
Founder and Director, Pulmonary Laboratory Holyoke Hospital, 1963-1978
Organizer and Director of Holyoke Hospital Family Planning Clinic, 1968-1978
Chief Pulmonary Medicine, Holyoke Hospital, 1977-1978
Organizer of Cardio- Pulmonary Laboratory, VAMC Northampton 1974
Full time Physician VAMC Northampton, MA 1978-present:
Director, Cardio- Pulmonary Laboratory, Pulmonary Rehabilitation Program, 1978- present,
Chairman of the Medical Emergency Committee and Organizer of the Hospital's medical emergency plan, 1978-1980
Member of Medical Education Committee for Physicians and organizer of Visiting Professor Series, 1978 to 1990
Co-Organizer of Exercise Training Program ,1982
Chairman of Medical Education Committee for physicians, 1990 -present
Chairman of Intermediate Medicine Quality Assurance Program, 1989- present
Member of the Intermediate Medicine Screening Committee, 1993
Program Director for the Hospice Care Unit, 1992-present
Director of Geriatric Evaluation,Management Unit, 1990- present
Environmental Physician, 1992- present
Clinical Pertinence Reviewer, Medical Service ,1990-present
On- site supervisor of Exercise Science Interns, University of Massachusetts Department of Exercise Science, 1984-

Adjunct Professor of Exercise Science, University of Massachusetts, Amherst, 1985

Licensure and Certification:
Commonwealth of Massachusetts: 26725
Diplomate American Board Of Internal Medicine ,1969
Member, Critical Care Council, American College of Chest Physicians, 1983
Elected Member, New York Academy of Science, 1984
Fellow American College of Chest Physicians, 1969

Fellow American College of Physicians, 1985
Diplomate in Geriatric Medicine, 1990
ACLS Recertification, 1992
Member Massachusetts Medical Society and Hampshire County Medical Society

9 Nov16,1993 Statement of Myra B. Shayevitz, M.D., FACP

Veterans Affairs Medical Center, Northampton, MA 01060

Publications:

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It was at this time that my civilian doctor refused to treat me any longer. That was when I turned to the VA for help. I had read articles on how the V.A. was looking for veterans like myself. I first saw Dr. Shavitz in Jan 1993. First, she changed my stomach medicine to a stronger one. The Tagamet I was taking was not controlling my stomach distress problems. Next, she started me on a mega vitamin therapy. She did this because of my advanced debilatated state. More recently we've begun diet modification therapy. Since I've been seeing Dr. Shavitz my condition is still not cured but it has improved somewhat. I've only had one severe episode of symptoms [illegible] only two attacks of moderate severity symptoms. The last one, a few months ago, was much milder than in the past. The [illegible] of mild individual attacks of symptoms are less pronounced.

Respectfully Yours
Walter [illegible]
514-42-3042
21 Joffre Ave
So Hadley, MA 01075-1820

Gentlemen,

My name is Paul E. Perrone. I was an Active Duty Member of the Air Force for over 5 years. After my 7 month tour in S.W. Asia I was stricken with a list of medical problems which are well documented in my Air Force Medical Records. In the interest of time I will just say I was a victim of Gulf War Syndrome. My Air Force Doctors at first suspected some sort of Muscle Wasting Problem. Then they came with there catch all diagnoses, STRESS' I put up with there neglect for over a year then in August of 1992 I bitterly separated from active duty. I was denied do process and no medical discharge was granted

When I checked into the V.A. hospital I was diagnosed with Asthma after I was given a breathing test A test the Air Force neglected to do. I continued to go back and forth to the V.A. with these problems Frustrated and Broke I desperately started looking for answers After 7 months I got in contact with Dr. Nick Ashford of M I.T. Dr Ashford told me it sounded like I had Chemical Sensitivity and gave me the name of Dr. Myra Shayevitz of the V.A. Medical Center Northampton, Ma I decided to go see Dr. Shayevi in March of 1993.

Dr. Shayevitz ordered all the test the V.A would allow. She noticed slight abnormalities with most of them. Including damage to the part of my brain that controls vision. The Occipital Lobe Dr. Shayevitz had me stay at the hospital for about six weeks. She watched my activities and continued to do test. Finally Dr. Shayevitz made the diagnoses. Multiple Chemical Sensitivity Syndrome A diagnoses the V.A. does not accept A diagnoses, I did not accept'' Dr. Shayevitz pleaded with me to try some of the environmental controls. Slowly I started to do as she asked. I took the vitamins she prescribed and ate the foods she recommended. After A few weeks I started to feel a little better.

Today, after 8 months of Dr. Shayevitz's care I am able to function once again. Although I have a way to go yet and some days I can not get out of bed. I shutter to think of the condition I would be in if not for her. I started telling sick veterans all over about this doctor from Northampton, Ma. Who had helped me feel better. Soon her list of Veterans grew I can only speak for myself but I can tell you the vets I sent to Dr. Shayevitz seem to be doing better.

It is a 242 mile round trip for me to see Dr Shayevitz. A trip the V.A does not pay for. A trip I make at least once a month. Sick vets need help now!'' I urge you to give this doctor a chance.

Hopefully Yours.

Paul E. Perrone
Methuen, Ma 01

NAME Ivan E Velez

RANK USA/RET/E56 E8

PERIOD June 1969 to November 1991 (22 years)

LAST UNIT 3rd ACR Ft Bliss Texas

OVERSEAS TOUR Vietnam Germany Italy Turkey, Puerto Rico, Panama and Persian Gulf

PERSIAN GULF SERVICE Sept 1991 to Dec 1991 departed from Saudi Arabia on Dec 26 1991 Back Injury Medical Discharge November 1 1991

LIVING CONDITIONS Poor to very poor

ENVIRONMENT Sand storms flies poor sanitary conditions etc

EXPOSURE Heavy concentration of diesel oil and gasoline

SYMPTOMS Memory loss fatigue joint pains rash hoarseness headaches dizziness, etc

TREATMENT Heavy dose of vitamins air purifiers rotational diets inhalers steroids filter for water at home (shower and tap water) coating of carpeting etc

STATEMENT.

My name is Ivan E Velez US Army retired with over 22 years of military service This statement is submitted in good faith to let you know how I feel after my short time in Saudi Arabia during "Operation Desert Shield"

As a soldier you learn to adapt to the environment, you are trained for the unknown My job as a First Sergeant was to look out for the health and welfare of my soldiers in the theater of operation and get them ready for war I was in pretty good shape before my departure to the Persian Gulf But I believe after my return to the states for my surgery on my back that I started getting sick for reasons unknown to me

I never mentioned anything to anyone because I thought I was just experiencing some bodily changes at any given time I believe now that my health problems were related to my service with my unit in the Persian Gulf I served in the Army for over 22 years but my experience in the Gulf was a little bit different than what I had experienced in the past

Then in 1992 a month after my discharge from the army I felt that there was something wrong with me I became ill after visiting a store that was heavy in perfume odors I did not know that the heavy concentration of fumes was making me sick The I read an article in the Army Times and I realized that I was probably sick

But it was not until 1993 that I spoke to Dr Myra Shayevitz at the VAMC Northampton Mass and realized that I was probably suffering with MCS I was surprised to hear of an environmental disease but it was possible? So I was started on several treatments with different types of inhalers heavy doses of vitamins rotational diets and at home changes in my way of living etc Because of these changes I have noted some changes for the good I started feeling better Although I still have some problems I believe that sooner or later I will be well enough to become a productive individual

IVAN E VELEZ

V.A. Northampton P.10

After returning from a combat tour in Iraq in April 1991, I began to suffer from several ailments previously uncommon to me. I sought no treatment for any of these ailments until well after my December 1991 discharge from the U.S. Army. I assumed that they were post-combat or personal stress-related until their persistence made me decide to seek help.

The worst ailment was a recurring severe frontal headache, similar to that which I experienced after taking Pyridostigmine, a nerve agent preventative. Though I ceased taking the pills immediately in February 1991, I continued to experience these headaches until December of 1992.

Another problem I encountered was weight loss. Upon my return from Iraq in April 1991, my weight began to drop from a steady 165lbs to approximately 140lbs. over the course of about four months. I was unable to gain weight regardless of caloric intake or physical exercise.

Chronic fatigue was the most persistent of the ailments, lasting until May of 1993. I found myself fatigued regardless of the amount of sleep I had, and I also encountered problems with my short-term memory.

In May of 1993, I underwent a Persian Gulf Environmental Examination by Dr. Myra Shayevitz at the VA Medical Center, Northampton, MA. At that time, Dr. Shayevitz prescribed vitamins and instructed me to avoid all chemicals and petroleum products. My tests and x-rays were negative and I continued with the vitamins. I no longer suffer from chronic fatigue, my current weight is nearly 160lbs, and I haven't experienced a severe headache since the early spring of 1993. On my 9 November 1993 visit with Dr. Shayevitz, I reported no problems whatsoever and I feel that the treatment was wonderfully successful. I am, however, very concerned for those veterans who continue to suffer from Gulf War Syndrome symptoms and feel that much research is needed into this illness.

Glen R. Bona

11 Nov 93

To Whom It May Concern:

Veterans' Day is a time to honor all those who served this great nation and I think it only fitting that we recognize the members of our Veterans' Administration as well.

I was a marine machine gun team leader with B Company, 1st Battalion, 1st Marine Regiment, 1st Marine Division (Task Force Papa Bear) during Operation: Desert Storm. I am proud to say that I was decorated for my actions but I'm even more proud just to have served my country.

Upon my return home, my health seemed to deteriorate and I thought it best to seek medical advice. I went to the VA Hospital in Northhampton, MA where I was astonished by the respect and courtesy granted me by the entire staff, it was not at all what I'd expected. Here I was directed to Dr. Myra Shayevitz to whom I'd like to offer my personal heartfelt thanks.

My symptoms included never ending diarrhea and recurring sores in my mouth. After sending me through numerous and thorough conventional tests that found nothing and left me with little hope, Dr. Shayevitz decided to try a natural approach to my problem and it seems to have had a positive affect. She placed me on a natural food diet, advised me to refrain from products containing petroleum or other chemicals, and prescribed supplements to be taken daily.

I know I'm not speaking for all who served in the Gulf and I cannot say I'm completely "cured," but if some one can make another's life a little more comfortable, well that person deserves commendation and I feel compelled to offer mine. To one of the unrecognized veterans and her staff, I salute you.

Respectfully Submitted,

Nathan M. Walz

Nov 12, 1993

To Whom it may concern,

The following is an update on my health history. Starting almost a year after leaving the Persian Gulf I began to experience noticable fatigue. Little effort would spend my energy. Along with this was persistant joint Pain and a rash. Most painfull were severe headaches that occured on an occisional Basis

My Symptoms have progressed to frequent minor headaches which nothing seems to remove along with the severe ones. Rashes still come and go But more prevalent is Memory loss Short Term memory and attention span have been noticeable Affected.

Most recently I have come under the care of Dr Shayavitz After changing some Personal habits and reducing exposure to most all chemicals I have experienced more sustainable energy levels Generally I have a better feeling physically The Rashes, headaches and the memory loss still Persis and have not chaged to any degree

Sincerely -

James F Lewis

STATEMENT OF MG RONALD R. BLANCK

COMMANDER WALTER REED ARMY MEDICAL CENTER

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

November 16, 1993

Mr. Chairman and Members of the Subcommittee:

I am grateful to have an opportunity to once again appear before you to address issues relating to post-war health issues of our Persian Gulf War Veterans. The health of our Persian Gulf War Veterans is of paramount importance and concern to the Department of Defense and we will continue to muster the best possible medical response on their behalf.

I am submitting, for the record, a copy of the Health Assessment we conducted in response to the Czechoslovakian report which indicated that they had detected, in two isolated incidents, very low levels of a nerve agent and a blister agent in Saudi Arabia. Based on the levels reported and our knowledge of effects to chemical warfare agents, long term health consequences would not be expected. However, many Gulf War participants still have persistent illnesses which have defied explanation despite careful, comprehensive, and intensive medical evaluation.

The Defense Department remains open and vigilant to possible causes for these ailments and will continue to work closely with the Department of Veterans Affairs to unlock all possible answers for the cause of these illnesses.

We have already made great strides in evaluating earlier explanations for these illnesses and I am submitting for the record a brief information paper on our DoD efforts.

Although our attempts to identify the causes for these illnesses has been elusive so far, we will continue to care for these veterans and do our utmost to root out the reason for their lingering health problems.

HEALTH ASSESSMENT

Background

On 19 January 1991, two Czechoslovakian Nuclear Biological Chemical (NBC) units operating northeast of Hafar al Batin, in Northern Saudi Arabia, reportedly detected very low levels of what they claimed was nerve agent (GB). On 24 January 1991, a third Czech NBC unit was escorted by a Saudi Arabian official to a site a few kilometers northwest of King Khalid Military City (KKMC) where mustard agent (HD) was reportedly detected in a small patch of wet sand. There were no indications of any Iraqi actions on those dates in those areas that could have explained these detections. No other chemical warfare agents were detected prior to or following these two instances. Neither U.S. nor other coalition forces identified any chemical agents in the Persian Gulf Theater of Operations during The Gulf War.

Assumptions Used In Assessing Medical Effects

- The Czech detections of GB and HD were valid.

- A small number of U.S. forces may have been operating in the region where the GB detection occurred and could have been unknowingly exposed to the very low levels of GB detected by the Czechs. That concentration (0.05 mg/m^3) for a 40 minute exposure was used to assess the health risk.

- No U.S. forces were operating in the immediate vicinity where the HD was detected by the Czech unit.

Known Health Effects of GB and HD

GB (Sarin) Nerve Agent:

- Short Term Effects of GB: Nerve agent inhibits the enzyme cholinesterase which causes symptoms in humans:

  - Low Dose: No symptoms at all; in the worst case, some constriction of the pupils, runny/stuffy nose and mild to moderate breathing difficulty.

  - High Dose: Loss of consciousness, convulsions, respiratory arrest, vomiting, diarrhea, muscle twitching, and death.

• Long Term Effects of GB

- Low Dose: No known long term health effects in exposed individuals.

- High Dose: Mild to moderate psychological difficulties (forgetfulness, irritability, depression, and sleep problems) for several weeks after exposure; however, these symptoms would be short lived and would eventually resolve within 4 weeks.

HD (Sulfur Mustard Agent--Blister Agent)

• Short Term Effects: The short term effects occur 2 to 24 hours after exposure.

- Low Dose: Symptoms include redness of the skin, blisters, eye irritation, inflammation and breathing difficulty. In conjunction with these symptoms, HD can cause gastrointestinal effects (nausea, vomiting, diarrhea, and/or constipation), anemia, and psychological effects which resolve in days or weeks.

- High dose: Large amounts of HD over a short period of time can cause death (see Table 2 below).

• Long Term Effects:

- Low dose: There are no known long term effects for short term low dose. However, daily exposure to HD over a period of years may be linked to: respiratory conditions (bronchitis, emphysema, asthma, laryngitis, cancer), skin conditions (cancer and ulceration), eye disorders, bone marrow depression, sexual dysfunction and psychological disorders.

- High dose: Large amounts of HD can, over long periods of time, cause death (see Table 2 below).

Nerve Agent Exposure Symptoms

Exposure is expressed in unit of concentration (C), multiplied by exposure time (t). Typical units are milligrams of agent in a cubic meter of air for one minute. This is abbreviated $mg*min/m^3$. In general, an exposure to 50 mg/m3 for 1 minute, or 50 Ct, is equal to an exposure to 10 mg/m3 for 5 minutes.

Table 1: Nerve Agent Exposure Symptoms in Humans

Description	Ct ($mg*min/m^3$)
Pinpointed pupils	0.005-0.5
Extreme runny nose	0.5-15.0
Shortness of breath, tightness of chest	approx. 15.0
Uncontrolled movement of arms and legs	approx. 30.0
Death	approx. 35.0

As shown in Table 1, given a concentration of 0.05 mg/m^3 and an exposure of 40 minutes--the maximum possible concentration and exposure time in the Czech reports-- one would expect exposed individuals to exhibit only pinpointed pupils and a runny nose.

Blister Agent Exposure Symptoms

Exposure is expressed in unit concentration (C), multiplied by exposure time (t). Typical units are milligrams of agent in a cubic meter of air for one minute. This is abbreviated $mg*min/m^3$. In general, an exposure to 50 mg/m^3 for 1 minute, or 50 Ct, is equal to an exposure to 10 mg/m^3 for 5 minutes.

Table 2: Blister Agent Exposure Symptoms in Humans

Description	Ct ($mg*min/m^3$)
Eye injury	100-200
Respiratory incapacitation	150
Incapacitating blisters	2000
Death (respiratory)	1500
Death (skin absorption)	10000

Medical Experience During The Persian Gulf War

There were no reports of service members exhibiting those signs or symptoms listed in Tables 1 or 2 which would be expected after exposure to GB or HD. Soldiers manifesting such symptoms would be expected to report to sick call and would be identified by health care providers and the disease and injury surveillance system; this did not occur.

There is no medical nor epidemiological documentation to link the unusual and ill-defined symptoms reported by some Persian Gulf War Veterans to exposure to GB or HD. No causal or temporal relationship can be identified between a potential chemical exposure in January 1991 and the symptoms reported in 89 individuals from various units participating in the

Persian Gulf Theater of Operations who have been evaluated at Army medical treatment facilities since the Gulf War.

Summary

There is no credible evidence that the GB or HD reportedly detected by the Czech NBC teams, when viewed in the context of all other known facts and information, would have presented a health threat to U.S. forces operating in the Persian Gulf Theater of Operations. Although US and coalition forces were also aggressively monitoring for NBC agents, no chemical agents were identified.

There were no reports of a single U.S. service member being treated at any of our medical facilities for chemical agent exposure. Furthermore, it is important to note that the Czech report did not indicate that any of the personnel operating in the area of alleged chemical incidents experienced any symptoms of exposure to chemical agents. Even under the worst case analysis, given the Czech reports, one would expect no symptoms or, at the worst, mild effects; and no long term health effects. In conclusion, there is no reasonable linkage between these incidents and those Gulf War veterans reporting persistent health problems.

TECHNICAL ASSESSMENT

OVERVIEW

This technical assessment consists of three parts: a description of two different chemical agent detections by Czechoslovakian reconnaissance teams; a description of the U.S. protocol for verifying threat use of chemical weapons; and, a description of U.S. Army chemical detection organization and capabilities.

Czechoslovakian forces reported the detection of chemical agents in two separate incidents. Other coalition force units were within 25 kms of this location. Approximately five days later, the Czech forces reported a mustard agent detection. No other unit reported a chemical detection during this period, or at any other time during the Gulf War. A detailed summary of these incidents is in Part 1 of this assessment.

The internationally-accepted requirements for verifying use of chemical weapons are extensive. Verification requires corroboration by a variety of means. A discussion of this is in Part 2 of this assessment.

Part 3 of this assessment outlines U.S. Army detection capabilities. Army units were equipped, staffed, and trained for chemical detection. Personnel were alert for the signs of chemical attack and were actively monitoring. The medical personnel were trained to recognize the symptoms of chemical agent exposure. No chemical detections or incidents of exposure were reported by Army units.

16 November 1993

INFORMATION PAPER

SUBJECT: Post-Persian Gulf War Health Issues

1. Purpose: To provide current information to Congress about Department of Defense efforts to address health issues among Persian Gulf War veterans.

2. Facts:

a. Many preventive measures were taken to protect US servicemembers from diseases and environmental threats known to exist in the Persian Gulf area. However, "unexplained" or "mystery" illnesses have occurred and have been widely publicized. Some illnesses are due to common medical problems expected in any civilian population; some are difficult to diagnose even after extensive evaluation at civilian, Department of Veterans Affairs and military medical centers. Several possible causes for these illnesses have been investigated and are summarized here.

(1) KUWAIT OIL FIRES. While the fires were still burning, the US Army Environmental Hygiene Agency began two comprehensive studies of exposure to oil well smoke. The Risk Assessment Study is to project the long-term health effects from this exposure. A report is due by the end of this year. A companion study measures biological markers of exposure to oil well smoke. The preliminary evidence from both studies suggest no long-term adverse health effects from this exposure.

(2) LEISHMANIASIS. The last case of visceral leishmaniasis was diagnosed in May 1993 and the last case of cutaneous leishmaniasis in April 1993 for a total of 31 cases. About 100 individuals have been extensively evaluated for the possibility of leishmaniasis, but confirmatory tests have been negative. Research is ongoing to find reliable screening and diagnostic tests for leishmaniasis.

(3) PETROCHEMICALS. In August 1992 the Army Surgeon General's office convened a panel on petroleum exposure composed of experts in toxicology, occupational medicine, internal medicine, and epidemiology from governmental, academic and private institutions. They concluded that petrochemical toxicity was not the a reasonable cause for unexplained illnesses.

(4) DEPLETED URANIUM. Soldiers with the highest potential exposure to depleted uranium have been evaluated and have not shown harmful uranium levels in their systems. No significant long-term health effects are expected. This study is still ongoing with further medical evaluation planned.

(5) CHEMICAL WARFARE AGENTS. A health assessment of the chemical agents detected by the Czechoslovakians demonstrated that, even under the worst case analysis, the very low levels of agent detected would have produced no significant long-term health effects in exposed persons.

b. DISABILITY ISSUES. The US Army Physical Disability Agency policy is to adjudicate cases on an individual basis to determine if a soldier is fit for duty. If the soldier is found unfit for duty, then disability is determined by rating the soldier's functional impairments. As of 21 October 1993, a total 47 cases have entered the disability system for problems due to the Persian Gulf War. Thirty-one soldiers have been found unfit for duty, 9 soldiers fit for duty and 7 soldiers pending adjudication or further evaluation.

c. Three Department of Defense initiatives:

(1) WORKING GROUP. A working group of internationally recognized physicians has begun the analysis of the medical records of Persian Gulf War veterans showing unexplained health problems. This group is collaborating with the three services and the Department of Veterans Affairs to establish viable definitions for the unexplained illnesses. In addition, consultation is ongoing with physicians who report success in diagnosis or treatment of veterans with unexplained illness.

(2) MULTIPLE CHEMICAL SENSITIVITIES. The Army Medical Department is evaluating the role of multiple chemical sensitivities in causing some of the unexplained symptoms reported by Persian Gulf War veterans. Funding has been requested for a research facility to study multiple chemical sensitivities.

(3) DEPARTMENT OF DEFENSE REGISTRY. The United States Army and Joint Services Environmental Support Group is constructing a Department of Defense Registry which contains a file on every military person who participated in the Persian Gulf War. This part of the Registry is nearly complete. The registry will ultimately contain information on the daily position of military units. When used in combination with exposure data, the registry will be able to determine the relative health risks for different units who participated in the Persian Gulf War.

d. In conclusion, the military health care system has sought extensive consultation from within and with outside agencies and individual experts in addressing the issue of Persian Gulf War veterans' medical symptoms. The health and well-being of our service personnel is of paramount concern to the military leadership. The Department of Defense and the Department of Veterans Affairs will continue their investigations and treatment of symptomatic veterans who served in Southwest Asia in support of the Persian Gulf War.

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STATEMENT OF

THE HONORABLE JESSE BROWN

SECRETARY OF VETERANS AFFAIRS

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HOUSE COMMITTEE ON VETERANS' AFFAIRS

November 16, 1993

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before this Subcommittee provide the status of Department of Veterans Affairs (VA) Persian Gulf-related activities.

We are and have been proactive ever since I took office on matters pertaining to Persian Gulf veterans. VA has undertaken a significant number of actions to address the health concerns of Persian Gulf veterans. We have learned from VA's experience with Agent Orange. We have looked at all possibilities and have asked for recommendations from all possible sources and are doing everything we can to get answers to these and other questions. I want to assure you that as VA analyzes information gathered through our registry, exams, and statements from veterans, we will honor our obligation to give veterans the benefit of reasonable doubt as we confront this sensitive issue. We certainly welcome any suggestion from this Committee. Tell us what actions you think we should be taking and we will give them every consideration. I will now tell you what VA has already done to address the medical problems of Persian Gulf veterans.

You may recall, initial Persian Gulf-related concerns focused on the possible health effects of exposure to pollutants from the oil well fires. VA and DoD worked closely to learn who could have been exposed to these pollutants and what was known about the effects of the pollutants on humans. As time went on, it became apparent that there may be a number of explanations for the many complaints being voiced by Persian Gulf veterans and their family members. Consequently, the focus of the investigation has been broadened to include additional potential environmental hazards.

In 1991, VA established a registry modeled on VA's Agent Orange and Ionizing Radiation registries. We offer a comprehensive physical examination, baseline laboratory tests, and other tests when indicated. The information derived from these examinations is entered into a computerized data base with the results closely monitored to discern patterns of illnesses or complaints among Gulf War veterans. While we are seeing a wide variety of symptoms, we are unable to identify any trend or pattern. As of

September 30, 1993, approximately 10,000 veterans had reported for an initial ("first-time") registry examination.

Office of Technology Report

The Office of Technology Assessment (OTA) report, mandated by Public Law 102-585 and released September 1993, assesses the utility of the VA Persian Gulf Registry examination program. The report concluded that a "good start has been made on all facets of the registry complex." OTA made a number of recommendations and VA has taken action to implement their suggestions. The report suggested that VA should immediately revise the examination protocol. In two days, on November 18, Persian Gulf Referral Center staff will meet with the Associate Chief Medical Director for Environmental Medicine and Public Health to finalize plans for utilization of the newly proposed addendum to the examination protocol. The OTA report also cited some areas in which VA and DoD may be better able to work together and share information. We are currently working with DoD to implement the recommendations of using uniform terminology and establishing a joint oversight body for the VA and DoD registries to enhance coordination and cooperation.

Legislation

During the past year, VA and the House and Senate Veterans' Affairs Committees have been working on legislation to address special eligibility for care of Persian Gulf veterans based on possible exposure. The House version, H.R. 2535, was favorably acted upon by the House of Representatives on August 2. The Senate version, which is included in S. 1030, was reported out of this Committee on September 8, and is awaiting action by the full Senate. This is important legislation and I urge that both Houses of Congress act upon this measure before the end of the Session.

Treatment

When a veteran's medical condition may be a result of environmental exposure, VA provides that treatment at VA facilities. If a Persian Gulf veteran presents unusual symptoms which cannot be diagnosed, a referral may be made to one of three special referral centers located at VA medical centers in West Los Angeles, Houston, and Washington, D.C. These centers were selected on the basis of availability of clinical and academic expertise in such areas as pulmonary and infectious diseases, immunology, neuropsychology, and access to toxicology expertise. As of October 31, 1993, there have been 52 admissions of such referrals and 49 discharges. Twenty-five more veterans are currently being scheduled for care at these referral centers.

Research

While considerable effort is made to learn the cause of a veteran's medical problems, in some cases a definitive diagnosis has proven to be elusive. This is a frustrating fact of medicine. To address this problem, we have sought expert medical advice and are beginning a special research initiative. Earlier this year, we established a "Persian Gulf Expert Scientific Panel," a sixteen member panel composed of experts in environmental and occupational medicine and related fields from both government and the private sector and representatives from veterans service organizations. The panel met in May 1993 and considered issues related to the diagnosis, treatment, and research of Persian Gulf-related health conditions. Panel members provided their thoughts on the complex scientific and medical variables associated with these conditions. This panel, which was chartered on October 16, 1993, will become a permanent advisory committee to the Department, with their first meeting planned for January 1994.

Out of my very deep concern over the possible health effects of military service in the Persian Gulf War, on June 28, 1993, I established a specialized Persian Gulf veterans working group to address the need for research into multiple chemical sensitivity. A panel was convened immediately and as a result of several meetings, including one at which six veterans service organizations were represented, a report was prepared recommending VA sponsorship of research into toxic environmental hazards.

On September 21, 1993, I approved the recommendations resulting from that panel, and we plan to release a special solicitation to establish VA research centers early next year. These centers will provide a nucleus of research activity in toxic environmental hazards much the same as was done in other areas of special concern for veterans, e.g., AIDS, substance abuse, and schizophrenia. The centers will serve as a focal point for coordination of research extending beyond VA in order to take full advantage of governmental and university resources. Activation of the centers is planned for the fourth quarter of FY 1994 following appropriate peer review.

Another activity planned by VA to address the issue of multiple chemical sensitivity is a Consensus Development Conference. We will bring together experts in the medical community who will endeavor to define this problem. Because differences of opinion exist as to the definition and scope of this problem, such a conference would permit public discussion of these differences and perhaps lead to a better understanding of the issues involved. The planning of this initiative is in the very early stages.

You may be aware that on August 31, 1993, President Clinton designated VA as lead agency for all federally funded research into health effects of the Gulf War. This

was in response to Public Law 102-585, section 707. I wrote to the Secretaries of Defense and Health and Human Services and the Administrator of the Environmental Protection Agency on September 29, 1993, requesting representatives to serve on the coordinating council that will be chaired by Dr. Dennis B. Smith, VA's Associate Chief Medical Director for Research and Development. We have been informed by HHS, DoD, and EPA that they will be willing participants. The Council will provide a mechanism for reviewing and coordinating the research activities related to the Gulf War. Within the next couple of weeks, VA will call a meeting of the agencies concerned and will consult with these other agencies and Departments before starting any other new Persian Gulf-related research initiatives.

Complimenting this effort will be the results of a review due in October 1995, of the existing scientific, medical, and other information on the possible health consequences of Persian Gulf service to be performed by the medical follow-up agency of the National Academy of Sciences.

Chemical Agents

Mr. Chairman, there has been a great deal of attention recently concerning the possible use of chemical weapons by the Iraqi government during the Persian Gulf War. The level of public concern was raised following reports by a Czechoslovakian Chemical Unit present in the Persian Gulf during the conflict, that traces of the nerve agent, Sarin, and blister agent, Mustard Gas, had been detected. A number of veterans have reported a variety of symptoms that they believe are related directly to their possible exposure to nerve or other agents. Particular concern has been raised by some members of reserve units that served in the Persian Gulf theater that they are now suffering the effects of exposure to chemical agents. Like Congress and the American public, the VA must rely entirely on the Department of Defense information for reports and findings relating to the events that occurred in the Persian Gulf. As you know, the U.S. team of experts that visited Czechoslovakia concluded that the Czechs did detect agents and VA plans to use whatever information is made available by DoD in our treatment and research efforts.

VA is very active in responding to the concerns of veterans. Even before DoD reported on the Czech data, the Birmingham VA Medical Center had been selected as the site for a pilot test to explore the matter further. A review of the literature on the effects of cholinesterase inhibiting agents, of which Sarin is one, has shown that human beings do experience long-term neurologic sequelae under certain circumstances. A specialized neurological examination protocol is being developed at Birmingham to determine if Persian Gulf veterans are experiencing neurological effects. Initial examinations will

focus on members of reserve units in Alabama and Georgia presenting possible neurological conditions, individuals who have participated in the Persian Gulf Registry at the Birmingham facility, and local veterans reporting to that facility with symptoms of concern. I must emphasize that such testing will not confirm whether or not the individuals were exposed to any particular agent. There is no screening test for cholinesterase inhibiting agents. The examinations will detect the types of disabilities which could result from exposure and perhaps provide clues for future diagnosis and treatment. We have a special obligation in this matter to draw our conclusions based on medical and other evidence. We need to give these veterans every benefit of the doubt while we accelerate and expand our efforts to resolve health problems among Persian Gulf veterans.

It is important to stress that, in the absence of biological or clinical markers, VA physicians cannot confirm exposure to chemical agents which may have occurred years ago. We can only confirm the presence of pathological changes which may be a result of exposure. The continuing uncertainties about exposures to chemical agents reinforce the need for VA to try to answer veterans' questions about whether their symptoms could be due to such exposures.

We intend to focus our efforts on reexamining Persian Gulf veterans with symptoms that could have been produced by exposure to chemical or other toxic agents while in the military. We will continue to seek reasons why veterans are sick and provide proper treatment with a goal of restoring these veterans to good health. These veterans deserve medical explanation for their illnesses. In proceeding with the development of focused research into other health issues that may have resulted from Persian Gulf service, it is clearly too early to rule out any conceivable cause of illness.

Disability and Compensation

Officials at VA have also been closely involved in issues regarding compensating Persian Gulf veterans for the disabilities they are experiencing. The Veterans Benefits Administration (VBA) has been collecting information on compensation claims in which disabilities were believed to be due to exposure to environmental hazards. With this information we hope to identify patterns of claims sharing a common environmental factor that may point to exposure to environmental hazards.

Our data indicate that the most common ailments claimed by Persian Gulf veterans as due to exposure to environmental hazards are respiratory complaints and skin conditions, including hair loss. Some veterans have had complaints involving symptoms of fatigue, insomnia, other sleep disorders, listlessness, weight loss, and digestive

problems. Making decisions on claims for disabilities due to exposure to environmental hazards is a priority for us. As of October 28, 1993, 1,472 claims from Persian Gulf veterans, who believe their disabilities are due to environmental hazards, have been decided. Service connection was granted in 79 of these claims. We have found that many claims cannot be favorably decided because a large number of claims are based on exposure only or on residuals without further specification of a disability.

Understanding the cause of symptoms similar to multiple chemical sensitivities and chronic fatigue syndrome is an integral part of our efforts in granting disability claims. Some individuals have labeled these conditions as the Persian Gulf mystery illness. While there may be a mystery surrounding the cause of the health problems some veterans are experiencing, there is no mystery to the fact that many veterans are ill and need help. I am pleased to report that criteria have been established to grant service connection for chronic fatigue syndrome. On November 9, 1993, instructions were sent to all regional offices detailing the requirements that must be met to establish service connection for this condition.

As to the multiple chemical sensitivity and Persian Gulf syndrome, VA does not at this time have a clear mechanism to establish service connection for these illnesses because they are not widely acknowledged in the medical community as disabilities. However, as we have already stated, we are providing medical services to veterans suffering from various health problems believed to have been incurred in the Persian Gulf War.

Additionally, we have been closely monitoring environmental hazard claims to determine if a pattern of ailments can be traced to a common origin. To accomplish this, claims processing has been centralized at the Louisville Regional Office. This action has provided the added benefit of developing a core of claims examiners with expertise in rating these issues. With very limited exception, all disability claims based on exposure to environmental hazards are handled in Louisville, Kentucky. In the event we allow deviation from this policy, such as with the St. Petersburg Regional Office cases involving exposure to a paint containing a chemical agent-resisting coating, we ensure that expertise is shared and communicated in such a way as to maintain integrity in the decision making process.

Lastly, I would like to confirm our commitment to looking for solutions to these problems. We intend to take advantage of every opportunity to meet with the Department of Defense and other Federal departments and agencies and we look to

Persian Gulf veterans themselves to assist us in resolving Persian Gulf-related health care issues.

This concludes my formal statement. I will be pleased to respond to any questions you may have.

STATEMENT OF CHARLES E. JACKSON, MD
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

November 16, 1993

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before this Subcommittee for the purpose of providing the status of Department of Veterans Affairs (VA) Persian Gulf-related activities.

In August 1992, the VA Medical Center in Tuskegee, Alabama began enrolling Persian Gulf veterans in the Registry. In view of the complaints about the vaccine, particularly Anthrax, that were received in the Gulf, complaints about recurrent diarrhea, joint pain, excessive fatigue, shortness of breath, and memory problems, the VA Tuskegee deviated from the suggested protocol of physical exam, c.b.c., chest x-ray, profile 8 (SMA 20) and urinalysis.

In view of endemic diseases of the Middle East, complaints of diarrhea, joint pain, and exposure to dead animals, the VA in Tuskegee systematically performed an expanded number of tests on the first 100 veterans seen on the Registry. Febrile Agglutins, Hepatitis Profile, ANA and Rheumatoid Factor, sed rate, Fungal Titre, and Immunoelectrophoresis (Serum) were performed on the first 100 veterans on the Registry. Where appropriate, stool cultures and stools for ova and parasite, and blood cultures were performed. All tests were normal except those discussed below.

Finally by September 1993, the VA Tuskegee had registered 180 individuals.

SUMMARY OF RESULTS OF 180 INDIVIDUALS ON THE TUSKEGEE REGISTRY

1. One hundred eighty (180) individuals have been seen and have almost complete statistics compiled from their Persian Gulf Registry exam. The results are these:

a. Twenty-eight (28) or 15% have complaints of recurrent diarrhea since the gulf.

b. Twenty-three (23) or 13% have complaints of excessive fatigue since the Gulf.

c. Twenty-two (22) or 12% have complaints of joint ache (fingers and knees) not associated with injury since the Gulf.

d. Twenty (20) or 11% have complaints of rash on extremities off and on since the Gulf.

e. Ten (10) or 6% have complaints of excessive shortness of breath which did not exist prior to the Gulf.

f. Three (3) or 1% had muscle aches and twitching which did not exist prior to the Gulf.

(Most people had more than one symptom and thus there is overlap. A total of 63% of the group were symptomatic.

2. Physical and abnormal laboratory findings were found in 26% of this group. No individual is in more than one category; thus truly 25% of the group of 180 have abnormal lab or physical findings. These are:

a. Elevated serum protein of 8.3 grams or greater - 14 or 11%.

b. Seropositive for HBV, 11 or 6% (none were icteric or gave history of hepatitis).

c. Hypergammaglobulinemia was found in 8 or 4% of the group.

d. Lymphadenopathy, generalized, was found in 4 or 2%.

e. Sed rate was elevated over 30 in five (5) patients or 2%.

f. Other abnormalities - candidiasis, thyroid disease, non-Hodgkin lymphoma, abnormal liver on echo, all 3%. Thus 25% or one-fourth of the group have abnormal lab or physical findings.

DEPARTMENT OF VETERANS AFFAIRS
DEPUTY ASSISTANT SECRETARY FOR CONGRESSIONAL LIAISON
WASHINGTON DC 20420
July 7, 1994

The Honorable Lane Evans
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

We received correspondence from your office dated June 13, 1994, stating VA did not respond completely to all of the questions submitted regarding the November 16, 1993, hearing on Health Care Problems and Concerns of the Persian Gulf War Veterans.

Enclosed are expanded answers to those questions indicated. We regret that the initial response was not completely responsive and appreciate the opportunity to submit this information for the record.

Sincerely yours,

Dennis M. Duffy

Enclosure
DMD/gya

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HEALTH CARE PROBLEMS AND CONCERNS OF PERSIAN GULF WAR VETERANS: THE RESPONSE OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE AND RELATED ISSUES

NOVEMBER 16, 1993

Question 11: Since several federal agencies reportedly recognize Multiple Chemical Sensitivity (MCS), why is it necessary for VA to conduct a consensus development conference on MCS? Will Dr. Shayevitz be invited to participate in this conference?

Answer: Although several federal agencies recognize Multiple Chemical Sensitivity as an entity, there are differences over the various symptoms that should be included within the syndrome. A specially-formed consensus workshop comprised of nationally-recognized experts in toxicology, environmental medicine, and other related disciplines, met at the end of April to address the feasibility of establishing a consensus definition of the "Persian Gulf Syndrome" which would entail, among other things, determining if it is a single illness or a combination of separate afflictions, and how it relates to Multiple Chemical Sensitivities. The workshop panel concluded that "it is impossible at this time to establish a single case definition." Dr. Shayevitz was invited to speak at the workshop and gave a 20 minute presentation on her professional experiences in treating veterans of the Persian Gulf War.

Question 14: Identify the medical test(s) administered at each of VA's Persian Gulf Referral Centers which cannot be administered at other VAMCs and identify the definite diagnoses made at each of VA's Persian Gulf Referral Centers which could not be made by personnel at the referring VAMC.

Answer: There are no medical tests or definite diagnoses made at the Referral Centers that absolutely could not have been made at another VA medical center. In some cases, the Referral Centers provided confirmation of diagnoses made at other VAMCs. In other cases, diagnoses were made in a more timely fashion by allowing for concentrated efforts at assessment. The purpose of the Referral Centers was to establish a cadre of individuals familiar with the various health issues affecting Persian Gulf Veterans, who could provide necessary treatment to veterans and provide consultation for other physicians.

Question 19: VA has reported it was proceeding, through a variety of approaches, to resolve these complex health issues of Persian Gulf veterans. Identify each of these approaches and what has been learned from each approach to date?

Answer: Most of the approaches listed in our original response to this question are still in progress. However, the results of our examinations of veterans in the Registry Program and at the

Referral Centers have indicated that there is not one condition or syndrome that affects all veterans of the Persian Gulf conflict, but a number of conditions which are at present imperfectly understood. This view was recently confirmed by the NIH Technology Assessment Workshop, which evolved out of the planned consensus conference. The one activity for which there is a preliminary report is the review of birth records of children born to veterans of selected National Guard units in Mississippi. The occurrence of birth defects and other health problems in that population is no greater than would have been anticipated given the expected rates in the general population.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HEALTH CARE PROBLEMS AND CONCERNS OF PERSIAN GULF WAR VETERANS: THE RESPONSE OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE AND RELATED ISSUES

NOVEMBER 16, 1993

Question 1: VA has reported, "it expects to solicit proposals early this fiscal year from VA researchers to establish from one to three research centers.

By when will VA make final decisions on establishing one or more of these research centers, what additional resources will be provided to each of these research centers and when will these resources be provided?

Will each center examine and treat veterans? Will the examinations and treatment provided by each center not be available at any other VA medical facility?

Will the expertise available at each center not be available at any other VA medical facility?

Answer: A VHA Directive entitled "Solicitation of Proposals for the Establishment of Research Centers for Basic and Clinical Scientific Studies of Environmental Hazards ("Environmental Hazards Research Centers")" was issued to the field on January 10, 1994. Applications for funding have been received and are currently being evaluated. One to three centers will be established and funded at a level of up to $500,000 a year per center per year. Funding will be initiated in fourth quarter FY 1994. As Research Centers, there is no explicit patient care role identified although it is expected that clinical studies will be initiated.

Responses to an earlier solicitation for pilot studies are currently undergoing review. These proposals will be funded up to $50,000 a year and will explore the medical consequences of exposure to environmental hazards. The Centers will draw on the knowledge and expertise that exist at the individual VA medical center. They will also draw upon non-VA sources including, affiliated medical schools, DoD, HHS and EPA. It is expected that the expertise available at the centers will be made available to other VA facilities.

Question 2: Identify research currently being conducted at VAMCs related to the health problems and concerns reported by Persian Gulf War theater veterans.

Answer: Intramural research (that is, research utilizing VA's own investigators and facilities) was recommended as a high priority by the VA's Persian Gulf Working Group, formed several months ago to determine the most effective course of action for VA on this issue. VA immediately began supporting research programs addressing different aspects of potential Persian Gulf-related afflictions.

Small-Scale Pilot Programs:

VAMC Birmingham, AL	Researchers will investigate medical and psychological effects of exposure to petrochemicals and other toxic hazards.

VAMC Jackson, MS	The Jackson VAMC is acting as an initial clearinghouse for data on reported birth defects in children of members of the Waynesboro (MS) National Guard.
VAMC Boston, MA	A project examining neuropsychological profiles of veterans returning from the Persian Gulf theater.

Psychological and Observational Studies

VAMC Clarksburg, WV	"An Investigation of the Relation between the Experience of Operation Desert Storm and Post-War Adjustment"
VAMC Mountain Home, TN	"Early Intervention with Appalachian Marine Reservists in Operation Desert Storm"
VAMC Boston, MA	"Desert Storm Reunion Survey"
VAMC New Orleans, LA	"Psychological Assessment of Operation Desert Storm Returnees"
VAMC Salt Lake City, UT	"Operation Desert Storm Follow-up Survey"

Question 3: How many times has VA's Environmental Epidemiology Service (EES) reviewed Registry medical data to generate a hypothesis for in-depth analytical study, what hypotheses have been generated, which hypotheses will be tested and when will these hypotheses be tested? Identify the hypotheses which will not be tested and explain why each hypothesis will not be tested.

Answer: Because the registry is comprised of self-selected veterans who may not be representative of all Persian Gulf War veterans, a conclusion of an association between Persian Gulf area service and any specific health problems cannot be made based on the registry data. However, unusual clusters of health problems observed in the registry may provide a suggestion of an association which then can be studied in a formal epidemiologic study.

To date, VA's Environmental Epidemiology Service has reviewed the registry data three times. The results of the review were presented to the VA Persian Gulf Expert Scientific Panel meeting on May 7, 1993, and the Interagency Persian Gulf Research Coordinating Council meeting on December 20, 1993. The most recent review was presented to the NAS/IOM Committee to Review the Health Consequences of Service during the Persian Gulf War on January 20, 1994.

Analysis of registry data to date has failed to suggest a hypothesis for indepth analytical study of any particular health conditions. However, it was found that disproportionately high numbers of persons having served in national guard units and reserve units irrespective of branch of service were reporting to VA for a registry examination. EES plans the following follow-up analyses.

1. Compare the complaints and medical diagnoses of the national guard and reserve unit personnel with others who served in the active units for relative frequency and types of complaints and medical conditions.

2. Ascertain the military experience of these personnel in the theater (types of unit, time, locations, principal duties, etc.) to establish any commonalty.

EES will continue to review the registry data periodically.

Question 4: Please explain why VBA does not recognize diagnoses which have been made by VHA physicians, e.g., Persian Gulf War Syndrome (PGS) and Multiple Chemical Sensitivity (MCS).

Answer: VA has been unable to grant service connection for illnesses classified under the catch-all terms PGS or MCS because PGS and MCS are not at this time widely acknowledged in the medical community as disabilities. Further, PGS and MCS do not describe specific disabilities but rather a variety of symptoms or diseases which seem to be of uncertain etiology.

Question 5: How many PG veteran claims for service-connected disability compensation has VBA denied in whole or in part because VBA did not recognize the disability? Identify these disabilities.

Answer: We do not have the number of claims denied because we did not recognize the disability. However, we believe that the number of such claims would be very small. Additionally, the type of condition most likely to fall into this category is a systemic condition which is now diagnosed as Chronic Fatigue Syndrome (CFS).

Question 6: How many PG veteran claims for service-connected disability compensation has VBA denied in whole or in part because the disability did not result from a disease or injury recognized by VBA?

Answer: We do not have these statistics.

Question 7: How many Gulf veterans for whom VBA has denied in whole or in part a claim for service-connected disability compensation are chronically ill? Disabled by chronic illness?

Answer: We do not maintain the information requested. The presence of a chronic disabling illness is not sufficient to establish that the illness is related to military service. Other factors are considered in making that determination such as whether the disability was incurred in or aggravated by service; whether the disability is a chronic condition occurring within one year following release from service; or whether the disability is one that is known to be associated with exposure to a specific environmental agent.

Question 8: What changes would VBA recommend in the adjudication of claims for service-connected disability compensation to enable the award of compensation to Gulf veterans who are disabled by chronic illness, but who do not have a disease or injury which is recognized now by VA?

Answer: In preparation for the June 9, 1994, House Subcommittee on Compensation, Pension and Insurance hearing on H.R. 4386, (Persian Gulf Veterans Compensation for Undiagnosed Illnesses), we are currently reviewing this matter and will state our views in the testimony we will be submitting for that hearing.

Question 9: Provide the requirements for service connection for CFS.

Answer: Attached is a copy of our Training Letter 93-5, which provides the guidelines for rating CFS.

Question 10: Since most claims for compensation based on environmental hazards are processed by the Louisville regional office, what checks and balances are being used by VBA to make certain these decisions are correct?

Answer: VBA's Compensation and Pension Service is collecting copies of rating decisions for veterans claiming disability which they believe to be the result of exposure to environmental agents to identify among other things, patterns of claims sharing a common environmental factor that may point to potential health hazards, if any. Additionally, like all regional offices, the C&P Service conducts a quality assurance review of the compensation work completed by the Louisville office. A representative sample of each station's cases is reviewed annually to ensure that all regulations, manual procedures and directives, including those emanating from Court rulings, are properly followed. VBA also conducts site surveys of regional offices to review the local adjudication division's understanding and compliance of regulations and procedures, in particular, the newer ones arising from Court of Veterans Appeals' decisions and new legislation.

Question 11: Since several federal agencies reportedly recognize Multiple Chemical Sensitivity (MCS), why is it necessary for VA to conduct a consensus development conference on MCS? Will Dr. Shayevitz be invited to participate in this conference?

Answer: Although several federal agencies recognize Multiple Chemical Sensitivity as an entity, there are differences over the various symptoms that should be included within the syndrome. A specially-formed consensus workshop comprised of nationally-recognized experts in toxicology, environmental medicine, and other related disciplines, met at the end of April to address the feasibility of establishing a consensus definition of the "Persian Gulf Syndrome" which would entail, among other things, determining if it is a single illness or a combination of separate afflictions, and how it relates to Multiple Chemical Sensitivities. The workshop panel concluded that "it is impossible at this time to establish a single case definition."

Question 12: What information related to the Persian Gulf War has VA requested, but not yet received, from DoD?

Answer: VA and the DoD have had a very cooperative relationship in their mutual efforts to resolve health care issues which have surfaced as a result of the Persian Gulf War. VA is not aware of any instance in which the DoD did not provide information requested by VA except in the following instances:

VA awaits responses to correspondence and verbal communique concerning the following issues:

o the extent of DoD's use of paint containing Chemical Agent Resistant Compound (CARC); identification of individuals involved in the use of CARC; unit assignments and locations; and whether protective equipment was issued.

o exposure to other environmental agents such as cement dust; CARC at locations other than Ft. Stewart, Georgia and Saudi Arabia; mustard gas; smoke from oil well fires; depleted uranium; chemical or bacteriological warfare agents; diesel fuel; and any other industrial or occupational environmental hazard.

Examples of how VA and DoD cooperate are as follows: In order to properly address concerns of veterans over exposures to possible environmental hazards, all individuals who served in the area need to be identified. To this end, the Defense Manpower Data Center (DMDC) prepared a computer file of 670,000 troops assigned to the Persian Gulf area during the war and transferred the file to VA's Environmental Epidemiology Service, which now has access to all demographic and military personnel data on troops stationed in the Persian Gulf. Additionally, inpatient medical data of Gulf veterans are being closely

TRNG LTR 93-5

November 9, 1993

Director (00/21) 211C
VA Regional Offices

SUBJ: Rating Chronic Fatigue Syndrome (CFS)

1. Chronic fatigue syndrome (CFS) is an illness characterized by debilitating fatigue and several flu-like symptoms. The VA recognizes this condition when diagnosed according to the guidelines published by the U.S. Department of Health and Human Services. This disorder has both physical and psychiatric manifestations and closely resembles neurasthenia, neurocirculatory asthenia, fibrositis or fibromyalgia.

2. The hallmark of CFS is the sudden onset of the illness, typically with flu-like symptoms which do not fully resolve. These symptoms persist chronically, or wax and wane frequently, and are accompanied by debilitating fatigue and malaise, and last anywhere from many months to many years. In order for a valid diagnosis to be made the symptoms must persist for at least 6 months. The symptoms are most severe in the first year of illness.

3. The diagnosis of CFS currently is one of exclusion. The following list is a synopsis of the criteria which doctors must use to make the diagnosis. The list is a guide and is provided for informational purposes.

A case of chronic fatigue syndrome must fulfill both of the major criteria. The diagnosis must then meet 6 or more of the 11 symptom criteria plus 2 or more of the 3 physical criteria; or 8 or more of the 11 symptom criteria.

a. Major Criteria

(1) New onset of persistent or relapsing, debilitating fatigue or easy fatigability in a person who has no previous history of similar symptoms, that does not resolve with bed rest, and that is severe enough to reduce or impair average daily activity below 50 percent of the patient's pre-illness activity level for a period of at least 6 months.

(2) Other clinical conditions that may produce similar symptoms must be excluded by thorough evaluation, based on history, physical examination, and appropriate laboratory findings. (The complete list of malignancies, autoimmune disorders, infection, chronic psychiatric disease or chronic use of major psychotropic drugs, chronic inflammatory disease, endocrine disease, drug dependency, side effects of chronic medication or toxic agent, or other known dieases is included in the medical literature available to physicians.)

2.

b. Minor criteria - Symptoms

(1) Mild fever (37.5 to 38.6 degrees Centigrade) reported by the patient; (2) Sore throat; (3) Painful cervical or axillary lymph nodes; (4) Unexplained or generalized muscle weakness; (5) Muscle discomfort or myalgia; (6) Prolonged generalized fatigue following exercise that would have been easily tolerated earlier; (7) Generalized headaches (type, severity or pattern different from headaches experienced before); (8) Migratory arthralgia without joint swelling or redness; (9) Neuropsychologic complaints (one or more) of the following: photophobia, transient visual scotomata, forgetfulness, excessive irritability, confusion, difficulty thinking, inability to concentrate, depression; (10) Sleep disturbances (insomnia or hypersomnia); (11) Description of the main symptom complex as initially developing over a few hours to a few days.

c. Minor criteria - Physical

(1) Low grade fever - oral temperature between 37.6 and 38.8 degrees Centigrade; (2) Non-exudative pharyngitis; (3) Palpable or tender anterior or posterior cervical or axillary lymph nodes.

4. The signs and symptoms of CFS affect the upper respiratory, lymphatic, neuropsychological and skeletomuscular systems. When rating a claim in which CFS has been diagnosed, rate the symptoms in the major body system affected using the appropriate diagnostic code for that system with an analogous code 6399 to represent CFS. For example, a veteran with a valid diagnosis of CFS and who has significant depression, fatigue, forgetfulness, irritability, confusion, and inability to concentrate equal to a generalized anxiety disorder would be rated under DC 6399-9400. The rating specialist must be aware of the requirements for a valid diagnosis of CFS and must question any diagnosis that is not fully supported by statements of major and minor (symptoms and physical) criteria. Evaluations will be assigned from zero to 100 percent based upon the symptom picture, level of impairment and the appropriate diagnostic code.

/S/
J. Gary Hickman, Director
Compensation and Pension Service

monitored and analyzed in comparison to Gulf-era veterans not stationed in the Gulf. Computer matching of the PTF file with the DoD roster of Persian Gulf veterans has helped identify 6,092 Gulf veterans and 6,265 Gulf-era veterans treated in VA hospitals on an inpatient basis since the study began. Lastly, a mortality analysis of all 670,000 Persian Gulf veterans on the DMDC file will be compared to a sample of Gulf-era veterans who did not serve in the Gulf area. Cause-specific mortality for both veteran groups will be compared and also compared to the number of deaths expected in the U.S. male population.

Question 13a: The Subcommittee understands VA's Persian Gulf Referral Centers deal with "very unusual and difficult diagnoses". How many Persian Gulf veterans who have sought treatment from VA have a very unusual and difficult diagnosis? How many Persian Gulf veterans with "very unusual and difficult diagnoses" have been referred to one of the Referral Centers and how many have not?

Answer: VA has made every effort to diagnose and treat Persian Gulf veterans presenting unusual and difficult-to-diagnose adverse health conditions at local VA medical centers. In most instances adverse health conditions have been diagnosed successfully at the medical center with appropriate treatment of symptoms. All veterans, with the exception of 4 individuals, have received a diagnosis for conditions for which they were admitted. VA's policy is that in those instances where it is not possible for the medical center to arrive at a diagnosis, referrals are made (following consultation with the Persian Gulf Referral Center staff) to the appropriate Persian Gulf Referral Center.

Question 13b: How many of the veterans referred to each VA Persian Gulf Referral Center have been examined by the referral center? How many of the veterans referred to each VA Persian Gulf Referral Center have not been examined by each center?

Answer: As of May 25, 1994, 101 veterans have been admitted and 98 of these were discharged from one of VA's three Persian Gulf Referral Centers located in Washington, D.C., Houston, Texas, and/or West Los Angeles. Examinations for an additional 50 veterans, as of that date, were pending at these facilities.

Question 13c: Who and/or what determines if and when a veteran is referred to one of the Persian Gulf Referral Centers and what criteria are used to make this decision?

Answer: Local medical centers make every attempt to diagnose unusual adverse health conditions presented by some Persian Gulf veterans. Referrals are only made following consultation between clinical staff of the medical center of origin and the referred center of jurisdiction. Such referrals are made when it is determined that it is not possible at the local level, to arrive at a definite diagnosis and that such a referral might assist in making that determination. It should be noted that some veterans, for various personal reasons, elect not to be referred to referral centers.

Question 13d: Describe the follow-up VA has provided each veteran following release from a Referral Center.

Answer: Following discharge of the veteran from the center, Persian Gulf Referral Center staff, routinely contacts the medical center which originally made the referral to provide medical findings/diagnoses, if any, made at the referral center, date of discharge and any recommendations made for continued medical care. Copies of medical documents pertaining to the veteran are provided to the referring medical center.

Question 14: Identify the medical test(s) administered at each of VA's Persian Gulf Referral Centers which cannot be administered at other VAMCs and identify the definite diagnoses made at each of VA's Persian Gulf Referral Centers which could not be made by personnel at the referring VAMC.

Answer: Medical tests provided at VA's Persian Gulf Referral Centers are not unique to those centers. Such medical tests are available at all VA health care facilities. However, what is unique to the referral centers is the availability of clinical staff dedicated to the medical evaluation of Persian Gulf veterans referred for special diagnostic workup. The Referral Centers also provide the opportunity for extended evaluation of these individuals with inpatient stays of approximately two weeks.

Question 15: Identify the expertise available at each Persian Gulf Referral Center which is not available at any other VA medical facility?

Answer: VA's Persian Gulf Referral Centers were selected based on the available medical expertise at each of the three centers. They were selected for three major reasons: because of their geographic location (East Coast, Middle U.S., and West Coast); because of their own special clinical expertise; and finally, because of their geographic proximity to other centers for military medicine, occupational health and toxicology. The Washington VA Medical Center was selected because of its expertise in infectious diseases and neurology, and its geographic proximity to military facilities such as the Walter Reed Army Medical Center. The Houston Referral Center was selected, in addition to the above reasons, because of its proximity to academic facilities having expertise in multiple chemical sensitivities and industry resources with expertise in petrochemicals. The expertise available at the Referral Centers (e.g., toxicology, neurology, dermatology, gastrointestinal, etc.) is also available, in most instances, at other VA health care facilities. The Referral Centers are unique in having a "team" approach in dealing with individuals referred to those facilities. This provides a more indepth, intensive diagnostic investigation of Persian Gulf veterans referred for examination. Veterans referred to the Centers usually have an inpatient stay of approximately 6 - 10 days and therefore, receive a longer range health surveillance and avoid the "fatigue factor" that may occur when multiple demanding medical tests are scheduled in an ambulatory care facility.

Question 16: What diagnostic procedures are available at each VA Persian Gulf Referral Center which are not available at any other VA medical center?

Answer: See response to Question 15.

Question 17: What has each VA Persian Gulf Referral Center accomplished which could not be accomplished at any other VA medical facility?

Answer: As previously noted, the Referral Centers provide VA with the opportunity to examine and develop a possible diagnosis for the conditions presented by some Persian Gulf veterans. In this regard, the Centers have successfully diagnosed the conditions of veterans who have agreed to transfer to those facilities for the long-term health surveillance not possible at other VA health care facilities. The team approach employed at each facility and utilization of multi-disciplinary approaches have assisted in achieving this record. The special physician coordinator at each facility also makes a valuable contribution, providing a point of contact for consultation with referring medical centers, indepth review of diagnostic work-ups on each patient, development of a comprehensive evaluation utilizing all relevant specialists and diagnostic tests, and

finally, the administrative management of patient scheduling, record keeping and follow-up.

Question 18: What improvements in the Persian Gulf Registry examination have been considered and rejected by VA? What improvements in the Persian Gulf Registry examination have been considered, but neither rejected nor implemented by VA? What improvements should be made in this examination?

Why shouldn't all Registry exams be expanded as have examinations provided by the Tuskegee VAMC?

Answer: VA is currently in the process of redesigning the registry examination diagnostic code sheet to provide for capturing more than three symptoms and diagnoses on registry participants. Recommendations for eliminating what the OTA believes to be non-statistically relevant information is also being considered. Regarding the examination process, VA is currently analyzing the types of improvement, if any, which may be required to meet the health care needs of Persian Gulf veterans. The examination now provides a comprehensive health picture of the current health status of registry participants. It is anticipated that the "Pilot" neurological examination project being implemented at the Birmingham VA Medical Center will assist in determining what additional tests may be required.

Question 19: VA has reported it was proceeding, through a variety of approaches to resolve these complex health issues of Persian Gulf veterans. Identify each of these approaches and what has been learned from each approach to date?

Answer: VA has undertaken several major initiatives, including among other activities: award of a joint VA/DoD contract on September 30, 1993, with the National Academy of Sciences for a review of the possible adverse health effects of Persian Gulf service; establishment of special Persian Gulf Referral Centers in Houston, West Los Angeles and Washington, D.C.; conduct at the Birmingham VA Medical Center of a pilot program to provide special neurobehavioral examinations to certain Persian Gulf veterans; examination of Persian Gulf veterans with undiagnosable adverse health conditions at the Jackson VA Medical Center including the review of birth records of children of these veterans to determine existence and cause of suspected birth defects; undertaking efforts to establish special VA research centers to deal specifically with Persian Gulf-related research issues. Health and other data now available are being analyzed, results of which are still preliminary.

In addition to these efforts, VA is closely cooperating with the DoD and other concerned Federal and non-Federal entities through special committees, cooperative research efforts (e.g., joint VA/DoD "Five-Year Health Surveillance" of Persian Gulf veterans wounded by depleted uranium munitions being conducted at VA's Baltimore VA Medical Center) and other activities, to assist in arriving at a research and medical consensus on the complex Persian Gulf-related health issues in question.

Question 20: VA has reported the Persian Gulf Registry exam includes a good general Internal Medicine history and physical examination capable of leading to the diagnosis of a wide range of conditions. Why is the Persian Gulf Registry exam failing to diagnose the health care problems of some veterans? What changes should be made in the Persian Gulf Registry exam to be able to diagnose health care problems which are not being diagnosed now?

Answer: VA believes that its registry examination process does provide for the ultimate diagnosis of most conditions presented by Persian Gulf veterans. The examination provided is a general physical examination designed to assess the current health status of the individual. When necessary, referrals are made to special clinics (e.g., pathology, rheumatology, dermatology, etc.) to provide additional diagnostic assistance. Nevertheless, there have been some conditions which have defied the diagnostic process and which require special attention such as referral to one of the three Persian Gulf Referral Centers. The inability to diagnose "all" health conditions is not peculiar to VA's registry. Health care institutions/facilities throughout the private sector are also confronted with this phenomenon on a daily basis. In such instances, the medical emphasis becomes one of treating the symptoms presented by the veterans/individuals. In most cases such treatments are successful and no further complaints are presented. VA is currently in the process of reviewing the registry examination process and alternatives to providing for the diagnosis of individuals presenting seemingly "undiagnosable" conditions.

Question 21: Describe the new or additional actions VA has taken since June 9, 1993, to increase veteran (including service members on active duty and reservists) awareness of VA's Registry program and assess the effectiveness of each of these actions? What new or additional actions could VA take now to publicize the registry program?

Answer: Since June 9, 1993, VA has continued to interface with the Department of Defense to coordinate our respective Departmental efforts to resolve the health care issues of concern. VA and the DoD, on September 30, 1993, entered into a joint agreement with the Medical Follow-up Agency (MFUA) of the National Academy of Science's Institute of Medicine for the Persian Gulf Health Study mandated by Public Law 102-585. Both VA and the DoD have transmitted the necessary resources to the MFUA for this purpose.

Earlier in 1993, VBA modified VA Form 21-526, Veteran's Application for Compensation or Pension, to include a question asking if the veteran wants his or her medical information included in the registry. If, however, a veteran files an application form which does not contain this question, a letter is sent to the veteran explaining the Registry's purpose and providing the veteran an opportunity to have his or her medical and other records included in the registry.

VA has also recently received approval to provide for establishment of a chartered advisory committee to address Persian Gulf health/research issues. This committee emanated from one of the recommendations of the special "Blue Ribbon" panel which met in May 1993, to provide VA with advice on how to proceed on the health care issues generated by the Persian Gulf War. Since June 9, VA has also established an internal "Persian Gulf Veteran's Working Group" to address the need and possible funding for research into multiple chemical sensitivities.

Approval has been given by the Secretary of Veterans Affairs to establish special research centers at existing VA facilities, a recommendation which originated from this special internal task force. Planning for the centers is underway and special solicitations for research proposals have been sent to researchers throughout VA's health care system. VA has also initiated a pilot program at the Birmingham VA Medical Center to investigate possible neurological and other impairments in some Persian Gulf veterans. Because it was only established very recently, there are no results which can be reported at this time. In response to one of the requirements of Public Law 102-585, VA requested consideration by the President, and was subsequently designated as the

lead Federal agency to coordinate Persian Gulf-related research. A research coordinating committee met twice in late 1993.

Question 22: What has VA's Persian Gulf Expert Scientific Panel learned from its examination of the concerns of veterans regarding the possible long-term health consequences of military service in the Persian Gulf theater of operations? How has VA utilized this information? How will VA utilize this information?

Answer: The expert panel met on May 7, 1993, to review a variety of health issues related to the diagnosis, treatment and research of Persian Gulf-related health conditions. The meeting was opened to the public and received considerable attention in the news media. At the conclusion of the all day session, panel members indicated that additional review and analysis of research, education and clinical issues are essential in view of the complex scientific and medical variables associated with these conditions. VA is considering what would be the most effective way to follow through on these issues. In October we received approval for a permanent advisory committee on Persian Gulf-related issues. This committee will follow-up on the ideas discussed at the panel meeting in May. The initial meeting of the committee was on February 1994.

Question 23a: According to a study conducted by Dr. Jessica Wolfe, based on data from over 2,000 Gulf War veterans, 18 months after returning to the U.S., 9.4 percent of men and 19.8 percent of women had PTSD. Almost 30 percent of men and 41.3 percent of women reported negative change in their physical health after serving in the Gulf.

Answer: The percentages in the first sentence should be 9.7 and 20.7, respectively. Also, the wording in the first sentence should be changed from "had PTSD," to "reported symptoms suggestive of PTSD."

Question 23b: Are the Persian Gulf War veterans included in this study representative of the Persian Gulf War veteran population and can the results of this study be generalized to the Persian Gulf War veteran population?

Answer: The veterans included in this study are not necessarily representative of the Persian Gulf War veteran population in general in that the study included only ARMY veterans from the New England area (i.e., returnees who came back through Ft. Devens, MA), was made up primarily of Reserve (22.2 percent) and National Guard (56.5 percent) members, and was based on self-reported information. (See Table 1 below for other demographic information.) Thus, the study results may not necessarily be generalizable to the Persian Gulf War veteran population as a whole. (Broader statistical review of Armed Forces demographics would be needed.)

However, this study does provide important information generalizable to a subset of the veteran population. Also, it represents a unique opportunity to examine patterns of readjustment and the factors that contribute to physical and mental health changes in the years soon after return from a wartime environment.

TABLE 1. Demographics of Study Popuiation at 18 Months Post Return (n=2315).

Average age	30.6 years
Average number years of education	13.2 years
Prior Vietnam service	7.5%

Gender (% female)		8.4
Marital status (% married)		7.7
Racial status		
	White	85.6%
	Black	6.3
	Hispanic	3.7
Rank		
	Enlisted	37.0%
	Non-commissioned officers	55.2
	Commissioned officers	7.8

Question 24: What has VA's Persian Gulf Family Support Program (PGFSP) accomplished and has it completed its mission? When will this program be terminated?

Answer: The PGFSP was charged under P.L. 102-405 with the task of providing marriage and family counseling to Persian Gulf veterans and their spouses and children. The program through its outreach perspective has provided marriage and family counseling services to many veterans and their families. It has also served to coordinate veterans' entry into the VA system and the Persian Gulf Registry. It has served in many situations as a referral mechanism to other community programs/resources needed by Persian Gulf veterans and their families. Through the active outreach to individual National Guard and Reserve Units the program has responded to the need to bring the VA to veterans in a way that has not been done previously. Social work staff attending the National Guard and Reserve Units have reached veterans that other outreach activities did not, 88.5 percent of the veterans seen state that they learned about the program via a social work staff briefing at their unit meeting. Social Work Service has also communicated with the various military services to facilitate referral of Persian Gulf veterans to the program as they are discharged from active duty service.

The Persian Gulf Family Support Program (PGFSP), in FY 1993, provided 12,648 counseling sessions to a total of 17,152 attendees. Outpatient visits totaled 14,547 at VAMCs which received special funding and additional staffing and 6,895 at the other VAMCs for a total of 21,442 at all VAMCs. Outreach activities to National Guard and Reserve Units were considerable and approximately 63,392 veterans were in attendance at these sessions. A total of 120,597 public service announcements were made via newspaper, radio and television informing the public of the program and serving as another outreach mechanism.

Authority under P.L. 102-405 to provide marriage and family counseling services expires September 30, 1994. Funding is available to continue providing the additional social work staffing to VAMCs through September 30, 1994. After that date, veterans who continue to require marriage and family counseling services and who are eligible will continue to be seen via Mental Health Clinic Programs, Social Work counseling services and other programs available at the VAMCs.

Question 25: What information is needed to establish a diagnosis of Persian Gulf War Syndrome with chemical/biological exposure? What tests are used to establish this diagnosis?

Answer: Efforts are currently underway at the Birmingham VA Medical Center to provide for the neurological examination of veterans to determine if their neurological impairments, if any are detected, are analogous to those which might be experienced from exposure to chemical/biological agents.

Through the research, health surveillance and other efforts previously discussed, VA and other concerned Federal agencies are attempting to define the health problems unique to the Persian Gulf. There are no tests which have been shown to provide an overall diagnosis of the effects of exposure to such agents.

Question 26: Which agencies or individuals has VA contracted with to provide a diagnosis for Persian Gulf veterans for whom it has not been able to establish a VHA recognized diagnosis? How many veterans has VA referred to these contractors? What diagnoses have these contractors provided?

Answer: VA's Houston Persian Gulf Referral Center currently utilizes the services of Dr. Claudia S. Miller, M.D., M.S., Assistant Professor, Environmental and Occupational Medicine, located at the University of Texas Environmental Health Center in San Antonio, Texas. Dr. Miller is employed part-time by VA to provide the necessary expertise in identifying and diagnosing conditions possibly associated with multiple chemical exposures. Dr. Miller has identified four veterans as having possible multiple chemical sensitivity (MCS), but these diagnoses have not yet been confirmed as valid MCS cases. The special knowledge and skills available to VA through the services of Dr. Miller are not generally available at other VA facilities.

VA has not entered into a contractual arrangement, at this time, with other outside agencies or individuals for the purpose of providing a specific diagnosis for any adverse Persian Gulf-related health conditions. Nevertheless, through its own internal review of Persian Gulf health issues, planned Persian Gulf-related research via VA "Environmental Research Centers," establishment of a chartered Persian Gulf Advisory Committee, a pilot neurological testing program at the Birmingham VA Medical Center, its contract with the National Academy of Sciences for a scientific review of the possible adverse health effects of Persian Gulf service and its cooperative endeavors with DoD and other concerned Federal Departments, VA will continue to seek the diagnosis of conditions presented by some Persian Gulf veterans. As noted in previous responses, VA believes that in most instances, the adverse health conditions of Persian Gulf veterans have been diagnosed and the appropriate medical care has been provided.

Question 27: Under what conditions or circumstances has or will VA contract with another agency or individual to provide a diagnosis for Persian Gulf veterans for whom it has not been able to establish a diagnosis?

Answer: VA would only contract with another agency or individual when it is determined that such referrals would be medically efficacious and that there is a reasonable expectation that a valid diagnosis could be reached by such referral.

Question 28: Which part or parts of VA's Persian Gulf War Veterans Health Registry medical exam have proven to be particularly useful for determining: occupation exposures; insect bites; infectious diseases; exposure to chemical and/or biological agents; consumption of contaminated food or drink; pesticide exposure; exposure to other environmental agents during service in the Persian Gulf War theater of operations?

Answer: VA's Persian Gulf War Veterans Health Registry provides veterans with a general physical examination of their current health status. Standardized tests are made available for this purpose (e.g., enzyme tests, blood/urine tests, chest x-rays and other tests as medically indicated by the examining physician. The examination is holistic in that the physician

attempts to arrive at a medical diagnosis using the results of such tests in addition to the usual medical inquiry and "hands-on" examination processes.

Question 29: Describe the results of VA contacts with Dr. Edward Hyman since June 9, 1993, concerning his treatment for Persian Gulf veterans.

What information has VA requested Dr. Hyman provide concerning his treatment for Persian Gulf veterans, when was this information requested and has Dr. Hyman provided the information VA requested?

Please evaluate Dr. Hyman's treatment methods?

Answer: Prior to June 9, 1993, VA made several requests to Dr. Hyman for his proposed Persian Gulf-related "chronic fatigue" research protocol. Despite such requests, the protocol was never provided to VA. Dr. Hyman indicated that the protocol was not finalized and essentially indicated that he did not wish to share this information with anyone else. VA invited Dr. Hyman to lecture clinical staff at the New Orleans VA Medical Center concerning his treatment methodology. He declined to do so on the basis that he was involved in other activities and did not have any interest in working with the medical center. VA has had no further contacts with Dr. Hyman concerning his proposed research protocol. The only other contact with Dr. Hyman involved one of his patients who requested medical care at a VA facility. The medical center requested any medical information which Dr. Hyman could share concerning the patient's medical history and treatment. Dr. Hyman refused to share any medical information with the medical center on that patient and indicated at that time that if the veteran continued to visit the VA facility he would no longer provide care to that individual. The patient subsequently elected to return for care from Dr. Hyman rather than receive medical treatment from the VA.

Question 30: What progress has been made by VA since June 1993, determining the cause or causes of the hard to diagnose health problems reported by some veterans with service in the Persian Gulf theater?

Answer: VA is continuing its intensive efforts to determine the possible causation of adverse health conditions presented by some Persian Gulf veterans. A number of suspected environmental exposure/experiences have been identified and are being investigated by VA, in concert with the DoD and other concerned Federal Departments, as possible causative agents for some of the illnesses reported by Persian Gulf veterans (e.g., exposure to oil, smoke, smoke byproducts, multiple chemical sensitivities, microwaves, parasites, inoculations, depleted uranium munitions, mustard gas/nerve agents, etc.). However, preliminary results of such efforts to resolve the extremely complex medical and research issues involved are not definitive. Nevertheless, VA believes that it has made good progress, as discussed in previous responses, in initiating the process which may ultimately assist in resolving these issues.

QUESTIONS SUBMITTED BY
HONORABLE JILL LONG
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HEALTH CARE PROBLEMS AND CONCERNS OF PERSIAN GULF WAR VETERANS: THE RESPONSE OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE AND RELATED ISSUES

NOVEMBER 16, 1993

Question 1: Two separate registries are used to track the health of members of the armed services who served in the Persian Gulf--the VA Persian Gulf Veterans' Health Registry and the DoD Persian Gulf Registry. The Office of Technology Assessment (OTA) was somewhat critical with the lack of coordination and standardization between these two registries. What steps has the DVA taken to ensure veterans on active duty have the opportunity to enter the VA Registry? Also, do the two registries now use standardized codes to identify the service member's race/ethnicity and service member's unit name? Has a joint VA/DoD permanent oversight group with responsibility for both registries been established?

Answer: VA is currently cooperating closely with the DoD to ensure conformity and integration, where possible, of the respective registry databases of each Department. VA has advised the DoD that it is prepared to include active duty military personnel in its Persian Gulf War Veterans Health Registry. Active duty personnel may submit examination information and completed code sheets prepared by military physicians to the appropriate VA medical center for inclusion in VA's registry database. When an appropriate referral is made by a military medical facility, VA will provide the examination and again, include medical and demographic data obtained from the examination process in the registry. When active duty personnel are referred to the VA facility for the examination, a billing is made to the military for that examination. The administrative process for the above procedures is already in place between the VA and the DoD for such referrals.

As regards the establishment of a joint VA/DoD permanent oversight group with responsibility for both registries, VA and the DoD are reviewing possible alternatives including utilization of the Persian Gulf Advisory Committee for which VA recently received charter approval. It is believed that this Committee, which will include scientific and technical representatives from both the Federal and the private sectors, would have the necessary expertise to provide oversight of VA and DoD registries.

Question 2: The OTA Report indicated that it would probably be beneficial for each item on the VA form to be reviewed with DoD to assure consistency and to evaluate the need for collection. Do you plan to implement this suggestion?

Answer: Yes. VA has discussed this issue with the DoD and both Departments are prepared, where possible, to take necessary steps to ensure consistency in the respective registry databases. Copies of VA's registry policies and procedures, including diagnostic code forms have been provided to the DoD for its information and review. Both Departments will continue to work closely together and with the OTA in our mutual efforts to integrate registry demographic and clinical data.

Response to questions submitted by Honorable Lane Evans,
Chairman Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs

Health Care Problems and Concerns of Persian Gulf War Veterans:
The Response of the Department of Veterans Affairs and the Department of Defense and Related Issues.
November 16, 1993

Questions for Dr. Myra Shayevitz
Director
Cardio-Pulmonary Laboratory, Pulmonary Rehabilitation Program and Environmental Physician
VA Medical Center Northampton, MA

January 7, 1994

1. During your appearance before the subcommittee you suggested a grand or unifying theory to explain the hard to diagnose health problems reported by some Persian gulf veterans and their family members. If possible, please elaborate on this possible explanation.

Multiple Chemical Sensitivity syndrome consists of multiple symptoms occurring in multiple systems and organs of the body as a result of exposure to a wide variety of chemicals most commonly, petrochemicals or pesticides ; the initiating event is frequently accompanied by exposure coupled with unusual stress. One theory holds that each individual has a total tolerable load of chemical, physical, and emotional stress, and when that load is exceeded, this syndrome may occur. One may postulate that the stress of the Desert Storm conflict coupled with the petrochemical/pesticide exposures there ,may well have resulted in this syndrome's occurrence in susceptible individuals. Furthermore, the National Research Council estimates that up to 15% of the United States population may be affected and therefore we could expect to see this problem in the spouses of some veterans.

The most logical explanation lies in the fact that although one end of the nerve of smell (the olfactory nerve) lies in the nose, the other end lies in the brain . In 1985, Shipley showed that many environmental chemicals enter the central nervous system via this pathway. (see reference below). The olfactory nerve connects directly with the hypothalamic/ limbic systems, the focal point in the brain which governs the interaction between the immune, autonomic nervous and endocrine systems, the area of the brain which governs emotions, food cravings, immune function, digestive and metabolic activities of the gastro intestinal tract and reproduction. It is exactly in those areas in which we see the symptoms of the Gulf War Veterans.

Once this syndrome occurs, the brain cells in the hypothalamus/limbic area become "kindled" or sensitized. The sensitivity generalizes from the original agents to low doses of chemically unrelated substances such as perfume, alcohol, common foods (foods are themselves mixtures of organic chemicals) , tobacco smoke, auto exhaust, newsprint, previously tolerated medications and household cleaning chemicals. The smallest exposure "triggers" an amplified neuronal response in the brain and the syndrome is perpetuated.

The incitants are in such common usage that our veterans are literally always at risk of exposure. It is for this reason that the treatment consists of long-term avoidance of triggering substances to facilitate gradual improvement. The longer this syndrome is allowed to go untreated, the more environmental incitants perpetuate it, the harder it is to control, and the more likely it is that patients become chronically disabled leading to high individual and societal costs from lost productivity, social isolation and

health care requirements. I therefore recommend establishing a treatment program as soon as possible .

Also noted is that the sensitizing effects of the chemical overload experienced by our veterans, does not preclude direct toxic effects of chemicals on brain or other organ function, nor the presence of concomitant infections or malignancies due to altered immunity or other abnormalities such as altered function in body detoxification systems.

2. What problems are Gulf Veterans still having getting treatment from VA?

Although each veterans hospital has a designated environmental physician, no training in environmental medicine has been instituted. No literature delineating the treatment of Multiple Chemical Sensitivity Syndrome has been distributed and there have been no formal training programs. Because of this, the above explained hypothesis has not been tested and treatment has not been instituted. In fact, at the present time, there is not only a lack of physician education, there are no environmentally safe areas in VA facilities for examination and treatment.

3. What else should VA be doing to identify the cause (s)of Gulf veterans health problems?

1. A pilot clinical treatment program such as outlined by Northampton VAMC which will test a treatment hypothesis and gather invaluable clinical data.
2. Challenge testing under controlled conditions.
3. Testing of all symptomatic veterans for those abnormalities commonly found in MCS patients e.g. blood tests for toxic organic chemicals, highest resolution Spect Scans or PET Scans before and after chemical challenge, Quantitative EEG before and after chemical challenge, Blood vitamin and intracellular mineral levels, immunotoxicolgy panels, and tests of cognition. Furthermore, these should be done by highly experienced laboratories and personnel.

4. What changes should be made in the VA 's Persian Gulf Registry program and examination?

1. There should be a standard questionnaire addressing the following:
   - The exact exposure history including types and locations.
     symptoms
   - Home environment: type heat, presence of mold, dust, new furniture or carpets, location (e,g, near a gasoline station?) location of bedroom (e. g. above the garage)
   - Work history and Environmental history : before during and after the gulf specifically relating to any chemical or combustion products.
   - Hobbies as they relate to above.
   - Smoking , Allergy and Alcohol history
   - Past history and Family history especially as it relates to asthma and allergies as well as other medical and surgical illnesses and reproductive problems.

- Survey for Environmental triggers: e.g. symptoms exacerbated by pumping gas, going into malls, carpet stores etc. Temporal and location relationship of symptoms.
- Dietary survey to detect food sensitivities.

2. There should be chemically clean areas for examination.

3. There must be adequate time budgeted for educated physicians to evaluate these patients.

4. There should be an inter-disciplinary team which can help the patient with education in understanding his disease and avoiding incitants, proper diet, exercise, psychological support, family therapy and education and vocational counseling.
5. There must be adequate funding for an expanded protocol of lab investigation as described above.
6. Adequate funds must beallotted for the high quality nutritional supplements usually required and prosthetic devices such as protective masks and air purifiers.

References Olfactory Limbic Theory:

1. Shipley,M.T. (1985): Transport of Molecules from Nose to Brain..Brain Res Bull. 15:129-142

2. Bell,I.R., Miller,C.S. et al (1992) An Olfactory Limbic Model of Multiple Chemical Sensitivity Syndrome: Possible Relationships to Kindling and Affective Spectrum Disorders . Biological Psychiatry. 32:218-242

3. Burchfiel, James L.,Duffy, F.K. et al " Persistent Effects of Sarin and Dieldrin Upon primate EEG " Toxicology and Applied Pharmacology Vol 35 P 365-379

4. Bell I.R. (1993) Possible Time-Dependent Sensitization to Xenobiotics : Self-Reported Illness From Chemical Odors Foods. and Opiate Drugs in a an Older Adult Population Archives of Environmental Health Vol48 No.5 P.315-327

Responses to questions from the Honorable Lane Evans from the recent hearing held by the Subcommittee on Oversight and Investigation on Health Care Problems and Concerns of Persian Gulf War Veterans conducted on November 16, 1993. The American Legion submits the following responses.

Question 1: What problems are Gulf War veterans still having getting health care from VA?

Answer: As a result of visits to over 30 different Department of Veterans Affairs Medical Centers, we have found that most Persian Gulf veterans are having problems just getting scheduled for an initial exam. There is no continuity within the VA for treating Persian Gulf veterans. Many VAMCs tell veterans they must first be placed on the Registry before they can receive treatment. This causes a major problem. Veterans must first complete the administrative process and then be scheduled for a medical exam. Since many VAMCs use contract physicians to conduct the initial exam, only a few exams are scheduled per week. Getting on the Persian Gulf Registry can take up to 6 months to a year. Once this entire process has been completed, veterans are "Officially on the Registry." Then and only then can veterans receive treatment for the medical problems they are experiencing.

In The American Legion's view, this process is cumbersome, time consuming and inefficient for placing over 200,000 Persian Gulf War veterans on the Registry. Further, it is evident that the Department of Veterans Affairs has not provided the policy guidance to implement their own programs. There is no standard or continuity from one medical center to another (one hospital may have several persons assigned to work on the Persian Gulf Registry and another might have a person assigned in name only). The Secretary must place a higher priority on the Registry and make each medical center director responsible for its success.

Also, VA staff must recognize that "Persian Gulf Syndrome" exists and that certain medical problems are associated from service in the Gulf. In summary, problems related to medical treatment are:

- access to care
- not being treated until they are "Officially on the Registry"
- physicians not being able to make a diagnostic decision
- being denied or rated 0-10% for some minor unrelated injury
- not being advised by VA that a registry exists
- little or no follow up care provided by VA
- recognizing that "Persian Gulf Syndrome" exists

The American Legion feels that due to the lack of consistency, the Registry program is nct working and causing many problems among both staff and veterans.

Question 2: Are VA staff knowledgeable about the Registry program and what problems are veterans having with VA's Registry program?

Answer: Very few personnel at VA's medical centers have knowledge of the program. In most cases, the Registry is assigned to low grade staff in Medical Administrative Services. This assignment is usually an additional assignment and not part of the persons JOB DESCRIPTION.

Very little outreach is conducted. No PUBLIC MEDIA/SERVICE announcements are made and there is very little support from the director to make this a high profile program. Many veterans have lost faith in the Department of Veterans Affairs after one or two disappointing visits to a medical center. Most staff members do not recognize the fact that these

veterans are indeed ill. In fact, many veterans are told they are perfectly healthy. There is little effort to help find a solution in both medical practice and in staff attitude.

Recommendation: A job description should be assigned to the staff that is designated as the "Persian Gulf Coordinator." This person should work full-time maintaining the program.

Question 3: Are most Gulf veterans, including servicemembers still on active duty and reservists, aware of VA's Registry program?

Answer: Very few veterans are aware that the Department of Veterans Affairs has a Persian Gulf Registry. Of the thirty or so medical centers in the Eastern and Central Region that we visited, the average number of veterans that have completed both portions of the exam (administrative and medical) totalled about 15-20, with a low of 6 and a high of 70. These numbers are a clear indicator that the program is not working and that the word is not getting out. DoD does not inform departing servicemembers about the Registry. Most veterans learn about the program through friends, relatives, the media and Veterans Service Organizations.

Recommendation: VA should work closely with VET Centers and establish an outreach program. DoD provided VA with the names of 657,000 servicemembers who served in the Gulf. Veterans need to hear from an official government source (DoD and VA) about the Persian Gulf Registry. Veterans must be encouraged to participate whether they are ill or not.

Question 4: What special problems are Persian Gulf War veterans having with VA claims adjudication?

Answer: The main problem in the area of claims adjudication is that very few veterans are successful in having a claim allowed. The VA does not recognize disabilities associated with "Persian Gulf Syndrome." Also, the lack of a comprehensive physical exam is a contributing factor. Until Congress or the Department of Defense determines what disabilities are recognized as service-connected, many veterans have no alternative but to seek medical help and compensation from outside sources.

To get a claim filed a veteran must have a compensation and pension medical exam to determine , if, in fact, the disabilities are service-related. Only then can a veteran proceed with the adjudication process.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

HEALTH CARE PROBLEMS AND CONCERNS OF
PERSIAN GULF WAR VETERANS:
THE RESPONSE OF THE DEPARTMENT OF VETERANS AFFAIRS
AND THE DEPARTMENT OF DEFENSE AND RELATED ISSUES

NOVEMBER 16, 1993

QUESTIONS FOR MAJOR GENERAL RONALD R. BLANCK
COMMANDING GENERAL
WALTER REED ARMY MEDICAL CENTER
DEPARTMENT OF DEFENSE
[Congressman Evans letter of December 1, 1993]

1. Compare the health status and health problems of Persian Gulf War theater veterans to Persian Gulf War era veterans with no service in theater.

An epidemiological study with appropriate samples from the cohorts of Persian Gulf War-era veterans who deployed and Persian Gulf War-era veterans who did not deploy has not been performed to date by the Department. The Department is waiting on the findings of the reviews by the Defense Science Board Task Force on Gulf War Health Effects and the National Academy of Sciences to determine if such a study is to be conducted.

The Department of Veterans Affairs has created tabulations on discharge diagnoses for 6,092 Persian Gulf veterans and 6,265 Persian Gulf era veterans. The tabulations represent primary diagnoses from inpatient visits, with some veterans having more than one inpatient stay. A preliminary review of these data show essentially no differences except in the area of mental disorders with alcohol/drug dependence and adjustment disorders slightly higher for deploying Persian Gulf veterans.

2. The Army reported contracting for the services of a civilian physician of international stature to assemble a task force of civilian experts and military specialists to review a large number of clinical case histories of Gulf War veterans with ill-defined health problems. Who are the members of this task force and what has been gained from this review?

The Army contracted with Jay Sanford, M.D., internationally published and renowned expert in infectious diseases and former President of the Uniformed Services University of the Health Sciences, Bethesda, MD, to assess clinical case histories of Gulf

War veterans. The goal is to attempt to define a standard symptom complex to aid physicians in diagnosis as well as to suggest possible fruitful areas for research.

Dr. Sanford has completed his review and submitted his preliminary findings to DoD on January 27. The results of his study have been reviewed by DoD and VA physicians. With some modifications to the criteria, they hope to implement an interim case definition in the very near future.

In May, the Interagency Coordinating Board is sponsoring a conference at NIH to review research results and clinical data. They will attempt to develop a full case definition at the conference.

3. Which other coalition Persian Gulf veterans have been reported to have ill-defined health problems?

The Department of Defense does not currently have official information from the Coalition Forces on this subject. While unofficial inquiries indicate no other coalition force's veterans are exhibiting symptoms characteristic of our veterans, we intend to make official inquiries. Dr. Pearson, a representative from the United Kingdom and a member of our Defense Science Board Task Force on Gulf War Health Effects, has stated that no members of his country's military who served in the Persian Gulf are experiencing any problems that can be characterized as undiagnosed illnesses. A private attorney in the United Kingdom met with Senator Shelby and claimed to represent 50 individuals who have such symptoms but will not release the names or case descriptions.

MG Blanck accompanied Senator Shelby on two fact-finding trips to our coalition forces November 28-December 5, 1993 and January 3-15, 1994. MG Blanck states in his trip report the following:

- The Czech Republic has medically evaluated 23 (of 200) Persian Gulf veterans and none had symptoms related to service in the Persian Gulf. Seven are still being evaluated for conditions which are not believed to be due to Persian Gulf service.
- Of the Persian Gulf veterans in Great Britain who have reported health complaints, all had normal diagnoses with nothing unusual due to service in the Persian Gulf.
- The French are unaware of any service personnel with symptoms similar to that described by US veterans.
- Both Saudi Arabian and Israeli representatives (although not a coalition member, Israel has significant intelligence resources and medical knowledge of the Middle East) are not aware of any unusual illnesses in any of the populations (military and civilian) of Saudi Arabia or in Kuwait. Israel also is not aware of any unusual illnesses in the population of Iraq.
- Syria reports no unusual illnesses during or after the war for its Persian Gulf veterans.
- Egypt reports no illnesses in Egyptian forces who served in the Persian Gulf and are not aware of illnesses in any other Middle East forces who served.

4. Was any U.S. service member ordered not to report detection of chemical warfare agents in the Persian Gulf War theater? Biological Agents?

DoD is committed to full and open discussion of all information that may relate to the health problems of Persian Gulf War veterans. We are not aware of any case in which a service member has been ordered not to disclose possibly relevant information.

5. What would be necessary for DoD to confirm Czech reports of the presence of Sarin? How has DoD attempted to confirm Czech reports of chemical warfare agents in the Gulf theater of operations and what has DoD learned? What else could DoD do to attempt to confirm these reports?

The Czechs reported detecting low concentrations of Sarin in vapor form, during a period of about 40 minutes. Confirmation would have entailed a U.S. unit being present nearby during that time making the same identification, or a sample being taken for later confirmation in an independent laboratory capable of making and recording the identification. By the time U.S. units were able to get to the reported detection site, no agent could be detected; the Czechs took no sample for independent laboratory analysis.

DoD has met with the Czechs and discussed their oral accounts of their detections, which are credible; their technical procedures, which are valid; and performed a visual analysis of their equipment, which is capable of making the identification they describe.

DoD has arranged to examine the items of detection equipment used by the Czechs, and submit them to laboratory performance tests. These tests will better define the capability of the equipment, but will still not enable DoD to confirm the Czechs' findings in theater. However, we have accepted their reports as valid.

6. How has the U.S. attempted to determine if chemical/biological warfare agents were detected by any other coalition force(s) in the Gulf War theater of operations and what was learned from these efforts?

DoD has requested this information from coalition members as part of our overall investigation; we are still awaiting replies from several of these formal requests. Our informal discussions indicate that the Czechs and the French are the only forces who reported valid detections in the theater of operations.

7. The Subcommittee understands the M8AI Chemical Agent Alarm detects the presence of a nerve agent in 25 seconds or less, but the M256A1 Chemical Agent Detector Kit, used to confirm M8AI Chemical Agent Alarms, requires 25 minutes to confirm or deny the presence of a nerve agent.

Why does the M256A1 Chemical Agent Detector Kit require 25 minutes to confirm or deny the presence of a nerve agent detected by an M8AI Chemical Agent Alarm in 25 seconds or less?

The M8A1 Chemical Agent Alarm is an electronic ionization detector designed to give early warning of the presence of nerve agent vapor, so that troops can put on protective masks. The M256A1 Chemical Agent Detector Kit uses a variety of wet chemistry reactions, and is intended for use by troops already in protective gear to confirm the presence and identity of chemical agent. The M256A1 is much more sensitive and selective than the M8A1, and can identify other types of agents in addition to nerve agent. The full suite of tests contained in the M256A1 kit takes about 25 minutes, but the specific tests for nerve agent only require 15 minutes. The time is required for some of the chemical reactions to occur that indicate by color change the presence or absence of nerve agent.

Cite the advantages and disadvantages of using the M256A1 Chemical Agent Detector Kit to confirm of deny the presence of a nerve agent.

The M256A1 supplements automatic alarms by permitting the local commander to determine if the level of chemical agent in his area is at or below the threshold levels that can cause degradation in troop performance. It is more sensitive and selective than the M8A1 alarm, and also allows for confirmation of other chemical agents (blister and blood agents) as well as nerve agents. Operation of the kit is not instantaneous, but users are already in protective gear when operating this kit.

Compare the reliability of the M8AI Chemical Agent Alarm and the M256A1 Chemical Agent Detector Kit.

The mechanical reliability of the M8A1, and the sensitivity and selectivity performance of both the M8A1 and the M256A1 meet the Army requirement for chemical warfare detection equipment. Their reliability is not directly comparable, as one is an electronic device and the other is a small, self-contained chemistry set. However, the M256A1 is more sensitive and selective than the M8A1.

8. Please explain the failure of U.S. personnel to confirm any M8A1 chemical agent alarms.

If no M8A1 chemical agent alarms were confirmed as Under Secretary Deutch has stated, were M8A1 chemical agent alarms, the procedure used to confirm the M8A1 chemical agent alarms or both highly unreliable?

The lack of confirmation of chemical agent presence following an alarm does not indicate unreliability of either the equipment or the procedure; rather, the equipment and the verification procedures complemented each other as designed. Part of the design trade-off for having a sensitive and rapid-acting detector to provide early warning is that it is inherently more sensitive to a wide range of interferents. The field procedure calls for using a detector of different technology (usually the M256A1) to confirm the presence of a nerve agent; this is designed to "filter" those alarm events caused by some substance other than nerve agent.

What other possible explanations can you offer for the failure to confirm any M8AI chemical agent alarms?

There are only two explanations for an M8A1 alarm event followed by negative result of an M256A1 check:

(1) nerve agent was not present and the M8A1 alerted to some other substance
(2) nerve agent was initially present in a concentration sufficient to set off the M8A1, dissipated so quickly as to be undetectable by the more sensitive M256A1, while never reaching a concentration sufficient to cause human symptoms.

We believe the first of these two possibilities to be more probable. The M8A1 is known to false alarm to high concentrations of other substances found in a battlefield environment, while the M256A1 kit is not typically sensitive to the same interferents.

The second scenario is extremely unlikely, because the M256A1 is 10-100 times more sensitive to nerve agent than the M8A1. If an alarm was set off due to a low level of agent from a distant source, the subsequent use of the more sensitive detector kit would be able to detect presence of agent at levels far below that necessary to have initially set off the alarm. If a nearby attack had resulted in vapor concentration sufficient to set off the alarm, it probably would have also caused concentrations sufficient to cause acute symptoms in troops; the fact remains that no troops were reported to have died or shown acute symptoms from nerve agent.

9. Describe the methods used by U.S. forces to detect the presence of biological agents in the Gulf theater of operations and report what was learned.

U.S. forces operated air sampling devices to collect possible airborne hazards, and had the capability to detect the presence of anthrax and botulinum toxin in soil samples or in air sampler residues using monoclonal antibody "dipstick" test kits. Fifteen teams

were deployed by the Army to collect and analyze samples, and US Navy assets were also configured and deployed for biodetection and identification of other possible biological warfare materials.

Additionally, Army specialists provided consultation and hands-on assistance to UK, Canadian, and French allies. The UK and Canada developed and deployed reconnaissance vehicles, each of which included an air sampler, a particle sizer and various antibody-based tests (immunoassays). The French also deployed with antibody-based tests for BW agents with assistance from U.S. Army research facilities.

No evidence was collected by any BW detection means, or through normal medical diagnostic channels that indicated Iraqi use of biological warfare.

10. Are the hard to diagnose health problems reported by some Gulf War veterans communicable or possibly communicable?

Although we are unsure of the causes of the hard to diagnose health problems being reported by Persian Gulf War veterans, there is not a pattern of illnesses being demonstrated that strongly suggests a communicable disease cause for the illnesses. The Department has not excluded communicable diseases as a mechanism at this time.

11. What evidence will be considered by the independent panel Defense Under Secretary Deutch reported will examine the issue of chemical warfare agents in the Gulf War theater? Has DoD previously considered all evidence which will be considered by this panel? What evidence will this panel consider which has not already been considered by DoD? How will this additional evidence be obtained?

DoD is providing detailed briefings and data to the Defense Science Board Task Force on Gulf War Health Effects task force on information compiled to date. We are also arranging for briefings to be given by other individuals or agencies that can present information that the task force deems relevant. The agendas of the task force meetings are structured in line with the requests of the task force members. As independent researchers, these doctors and scientists have many other sources at their disposal beyond the DoD, and are considering information gained by all sources.

12. Describe the research currently being conducted and/or supported by DoD to identify the cause or causes of the hard to diagnose health problems reported by some Persian Gulf veterans.

A listing of the investigational activities being conducted by the Department is provided.

13. Should an epidemiological study of all Persian Gulf War veterans be conducted? Does DoD support such a study?

DoD and VA have mutually entered into a contract with the Medical Follow-up Agency, a division of the Institute of Medicine in the National Academy of Sciences, to address this issue. In addition, the Defense Science Board Task Force on Gulf War Health Effects is evaluating available data to assist in developing a decision about the advisability of specific types of epidemiological studies.

14. How many Persian Gulf veterans have been determined to be permanently or temporarily unfit for military service? What are the most frequent cause (s) of this determination?

The Services' Disability Boards are currently reviewing the records of individuals whose fitness for duty have been evaluated. To date, of the 3,014 cases reviewed, 2,386 have been found to be permanently or temporarily unfit for military service. The most frequent diagnoses listed for those found unfit for military service include arthritis, back pain, extremity problems, psychiatric problems, and cardiovascular disorders.

15. Describe DoD's contacts with Dr. Edward Hyman since June 9, 1993, concerning treatment for Persian Gulf veterans.

What information has DoD requested Dr. Hyman provide concerning his treatment for Persian Gulf Veterans, when was this information requested and has Dr. Hyman provided the information VA requested? Please evaluate Dr. Hyman's treatment methods. Does DoD consider this treatment to be investigational?

Upon public revelation of his findings, Dr. Hyman was contacted by DoD. He refused to provide any records or data, stating a basic distrust of the military's intent. Dr. Hyman later agreed to have a reputable physician personally visit him and review his data. Dr. Sanford traveled from Texas to Dr. Hyman's office and reviewed all pertinent records. It is Dr. Sanford's opinion that his data and methods are not spurious and are worthy of further investigation. We are currently working with the VA to see if other patients under a mutually acceptable protocol, could be evaluated by Dr. Hyman. We consider Dr. Hyman's work investigational but worthy of further evaluation.

16. What cause or causes has DoD ruled out for the hard to diagnose health problems reported by some Gulf War veterans?

The Department has not eliminated any potential cause from consideration in its investigations into the causes of the illnesses among Persian Gulf War veterans.

17. What progress has been made by DoD since June, 1993, determining the cause or causes of the hard to diagnose health problems reported by some veterans with service in the Persian Gulf theater?

There has not been any significant new information since June 1993 which would allow the Department to determine the cause or causes of the hard to diagnose health problems being experienced by some Persian Gulf War veterans.

Since June 1993, the Army Environmental Policy Institute has drafted the depleted uranium report; the Army Environmental Hygiene Agency has drafted the Kuwait Oil Fire Report, the Medical Follow-up Agency, a division of the Institute of Medicine in the National Academy of Sciences, has convened on Persian Gulf War health issues; the Defense Science Board Task Force has met several times to review these issues; Dr. Sanford's group has completed its review of medical records of some Persian Gulf War veterans with unexplained illnesses; independent investigators in multiple chemical sensitivities and infectious disease are developing research efforts; and the special surveillance program for reporting chronic conditions relating to service in the Gulf has collected more reports.

18. Which health problems are veterans with Persian Gulf War theater service experiencing more frequently than Persian Gulf era veterans without service in the theater of operations?

An epidemiological study with appropriate samples from the cohorts of Persian Gulf War-era veterans who deployed and Persian Gulf War-era veterans who did not deploy has not been performed to date by the Department. The Department is waiting on the findings of the reviews by the Defense Science Board Task Force on Gulf War Health Effects and the National Academy of Sciences to determine if such a study is to be conducted.

The Department of Veterans Affairs has prepared tabulations on discharge diagnoses for 6,092 Persian Gulf veterans and 6,265 Persian Gulf era veterans. The tabulations represent primary diagnoses from inpatient visits, with some veterans having more than one inpatient stay. A preliminary review of these data show essentially no differences except in the area of mental disorders with alcohol/drug dependence and adjustment disorders slightly higher for deploying Persian Gulf veterans.

19. Which biological warfare agent(s) did U.S. service personnel detect the presence of in the Persian Gulf War theater of operations?

U.S. and coalition forces did not detect the presence of any biological warfare agent.

20. Has DoD interviewed service members who have reported they believe they were exposed to and/or detected the presence of CW/BW agents? When will this be done?

DoD is interested in any service member's account of possible chemical/biological agent detection or exposure. In some cases, service members have been interviewed to determine if they knew of information that would be useful in helping to resolve the Persian Gulf health problem. In many cases, however, sufficient information has been gained from written accounts or public record testimony, and further interviewing has not, to date, seemed necessary. Congressional members or staffs who know of cases that they deem credible are encouraged to provide them to DoD for follow-up.

21. I have been informed by VA staff (Dr. Mather) that they first learned of the Czech detections through Senator Riegle's staff last summer. When was DoD first told of these detections?

We were aware of several of the Czech detections (those that were reported through Central Command) during the war; they were discounted at the time due to the lack of confirmation, no casualties, and no indications that the detections were in association with any military activity. Attention was recently re-focused on the incidents when the Czechs made a press release in July 1993 announcing that their detachments had made detections during the War. Following the interest of Congress in the incidents, DoD dispatched a team to investigate.

If DoD is fully cooperating with VA, why wasn't the Department informed that there was potentially credible evidence indicating that chemical weapons might have been used in the Persian Gulf?

While we consider the detection events credible, we do not believe that they indicate that chemical weapons were used by Iraq. The Czechs themselves discount the possibility that the detections were due to Iraqi military activity.

Are there any other detections that VA has not been informed about?

DoD has not yet determined any other reported detection incidents to be credible. During the war, we were aware that the French had reported detections to the Saudis but there were no confirmations and no reported physical symptoms of chemical agent exposure in any of the troops present. CENTCOM logs do record one French detection on January 21, 1991 but there was no reported confirmation. Senator Shelby was informed of the French detections during his recent fact finding trip to the Coalition countries. We are planning to formally request additional information from France on their detections. VA will be informed if any detections are determined to represent possible exposure to U.S. troops. A representative from VA is a full participant in the Defense Science Board Task Force on Gulf War Health Effects that is studying this and other issues.

22. While I understand that there were no independent confirmations of the Czech detections, I am troubled that DoD failed to fully investigate the credibility of the Czech reports until this Fall. Why did it take DoD so long?

There was no reason to investigate the reporting, in that it had been checked out by CENTCOM and the official reporting of the incident indicated that the US military had determined the Sarin reporting as a false positive. There were many such false positives during the war. There was no hostile military action associated with the timing of the Czech reports, and there were no other reports of the chemical agents made by units contiguous to the Czech positions. In short, it appeared at the time that they had simply had a false positive report.

23. Recently, DoD issued medical discharges for several service personnel based on medical chemical sensitivities. This appears to reverse DoD's previous pattern. What was unique about these men and women? How did their symptoms differ from those of other ill service personnel who served in the Persian Gulf?

The U.S. Army has medically retired only one soldier for a diagnostic impression of Multiple Chemical Sensitivity (MCS). This case was adjudicated prior to DoD's guidance regarding the management of cases such as these. This soldier was placed on the Temporary Disability Retired List with a reevaluation scheduled in July 1994. Since this case, there have been five other cases with findings associated with MCS. In none of these cases was MCS found to be an unfit for duty condition.

24. Our ability to detect biological warfare is extremely limited at best. Earlier this week, the Veterans Affairs Subcommittee on Oversight and Investigations heard testimony from a VA physician claiming that biological weapons were used in the Persian Gulf.

What evidence do you have to support the claim that such weapons were not used?

While our capability for early warning, real-time detection of biological warfare is limited, the samplers and field detectors that were in the theater were adequate to detect and identify the presence of Iraq's biological agents and toxins. Based on the preponderance of the evidence, there is no basis for suspecting that Iraq employed biological agents. This includes the absence of any reported occurrences of distinctive acute symptoms at the time of the conflict; absence of positive laboratory results from the testing of sample collectors which were in place in various areas of the gulf; and other intelligence information. While it is difficult to prove a negative, all the information available points to the conclusion that there was no use of biological warfare by Iraq during the Persian Gulf War.

25. GAO reported last year that our chemical weapons protection was often faulty and last week, the Veterans' Affairs Committee heard testimony from veterans who said that they were never issued MOP gear. Furthermore, they said that they were told that there was a shortage of MOP gear.

Were any service personnel sent in to the theater of operations without MOP gear and other protections from chemical/biological weapons?

DoD policy requires that all personnel deploying in theater (e.g., into the Persian Gulf theater) are issued individual protective gear prior to entering theater; however, there were some occasions in which units had to be issued some of their protective clothing after their arrival in theater (in order to expedite their arrival in theater). Stocks of protective clothing and equipment were sufficient for all US personnel participating in the operation.

How were our troops protected from such attacks? And how effective were these protections?

Troops were trained in the use and wear of their standard individual protective equipment, in the procedures for self and buddy aid, and for individual decontamination.

Since there were no chemical or biological attacks, we have no quantitative measure for how effective these protective measures would have been in the field. However, testing data, and daily use by personnel under chemical weapons depot and live-agent training conditions support our confidence in the effectiveness of fielded individual protective equipment.

26. Your conclusion that illnesses observed in many Persian Gulf veterans are unrelated to chemical weapons exposure is based, in large part, on the pesticide studies? How many studies have you reviewed that dealt specifically with low level exposure to Sarin?

Our belief that the illnesses in Persian Gulf veterans are unrelated to chemical weapons are based on chemical agent studies, not pesticide studies. About 48 studies have been identified in which small amounts of nerve agents were administered to humans. About 70 percent of these studies involve Sarin. Additionally, there are several reports of accidental exposure to Sarin by manufacturing or depot workers. However, the Defense Science Board Task Force on Gulf War Health Effects is evaluating the potential health effects of low level exposure.

What were the research protocols and findings of these studies?

The research protocols for these studies would take considerable time to explain. However, the findings indicate that after small amounts of Sarin vapor, the subjects had miosis, rhinorrhea, and complaints of a tight chest. Some had minor, transient neuropsychiatric complaints, such as forgetfulness and irritability.

Has the research that you have reviewed examined the effects of prolonged exposure (perhaps over a period of several weeks) to very low levels of chemical/biological weapons? What were the research protocols and finds of these studies?

Our research studies did not include the prolonged (i.e., over weeks) exposure of humans to chemical agents.

Have any studies been conducted to examine how low levels of chemical/biological weapons might interact with the other toxins that were present in the Gulf, such as petrochemicals, fumes of burning oil wells, experimental pharmaceuticals, and leishmaniasis? What do you believe that interactive effects of such exposures would be?

No. There is no pharmacological reason to believe that there would be a biological interaction between chemical agents and petrochemicals, fumes of burning oil wells, and leishmaniasis. However, smokes or inhalants of any type would aggravate airway damage from inhalation of mustard or nerve agents if the person were symptomatic from these agents.

THIS IS IN RESPONSE TO QUESTION #12

Persian Gulf Veterans Coordinating Board

Research

DoD Research Activities

Review of the Health Consequences of Service During the Persian Gulf War.
Action: National Academy of Sciences (NAS) - Medical Follow-up Agency
Purpose: As directed by P.L. 102-585, the NAS will review existing scientific, medical and other information on the health consequences of military service in the Persian Gulf theater of operations during the Persian Gulf War.
Coordinations: DoD, VA and HHS.

Cooperative DoD/VA Research.
Action: DoD and VA Medical Scientists.
Purpose: Support for partial funding of research on the health consequences of exposure to environmental hazards during the Persian Gulf War. Some of this research will take place at VA Medical Centers.
Coordination: DoD, VA and HHS.

Leishmania Research.
Action: US Army Medical Research and Development Command.
Purpose: Develop a blood assay for leishmania.
Coordinations: DoD, VA and HHS.

Epidemiologic Assessment of Suspected Outbreak of an Unknown Disease Among Veterans of ODS at the Request of the 123d Army Reserve Command, FT. Benjamin Harrison, Indiana.
Action: US Army Medical Research and Development Command.
Purpose: Conducted medical examinations and in-depth surveys of 79 soldiers with symptoms or concerns potentially linked to service in ODS.
Coordinations: DoD, VA and HHS.

Stress-Related Survey of Soldiers Deployed in ODS.
Action: US Army Medical Research and Development Command.
Purpose: To identify correlations between post ODS symptoms and occupational and environmental stresses. These questionnaires were completed by active duty and reserve Army, Navy and Air Force personnel in Hawaii and Pennsylvania. Data analysis is in progress.
Coordinations: DoD, VA and HHS.

Retrospective Studies Involving Military Use of Pyridostigmine as a Pretreatment for Nerve Agent Poisoning.

Action: US Army Medical Research and Development Command.
Purpose: Obtain safety data for pending New Drug Application to FDA.
Coordinations: DoD, FDA and VA.

Retrospective Survey of Troops Who Received Clostridium Botulinum Toxoid in the Gulf War.

Action: US Army Medical Research and Development Command.
Purpose: To conduct a retrospective survey of troops who received clostridium botulinum toxoid in the Gulf War after troops returned to the US.
Coordinations: DoD, VA and HHS.

Environmental Toxicology Studies.

Action: Armed Forces Institute of Pathology and Army Environmental Hygiene Agency.
Purpose: To conduct a series of studies in environmental and toxicologic pathology relating to exposures during the Persian Gulf War.
Coordinations: DoD, VA and HHS.

Monitoring Gulf War Veterans With Imbedded Depleted Uranium Fragments.

Action: Armed Forces Radiobiology Research Institute.
Purpose: Conduct clinical follow-up of ODS patients with known or suspected imbedded depleted uranium fragments and assess health risks from imbedded depleted uranium fragments.
Coordinations: DoD, VA and HHS.

Working Group to Establish a Working "Case Definition" for Post-ODS/DS Unexplained Illness.

Action: Walter Reed Army Medical Center.
Purpose: Review and analyze medical records of ODS/DS veterans with unexplained symptoms to establish a working "case definition" for post-ODS/DS unexplained illness.
Coordinations: DoD, VA and HHS.

Persian Gulf Veterans Coordinating Board

Research

VA Research Activities

Children of PG Veterans in Mississippi.

Action: VAMC Jackson.

Purpose: An examination of children born to Persian Gulf veterans for evidence of possible genetically determined health effects related to their parents' service.

Coordinations: VA, DoD and HHS.

Review of the Health Consequences of Service During the Persian Gulf War.

Action: National Academy of Sciences (NAS) - Medical Follow-up Agency

Purpose: As directed by P.L. 102-585, the NAS will review existing scientific, medical and other information on the health consequences of military service in the Persian Gulf theater of operations during the Persian Gulf War.

Coordinations: VA, DoD and HHS.

Pilot Program to Investigate Medical and Psychological Effects of Exposure to Toxic Hazards.

Action: VAMC Birmingham.

Purpose: Conduct pilot program to investigate medical and psychological effects of exposure to toxic hazards. Results of examinations provided to about 11,000 veterans on VA's PG Registry are also being reviewed to determine if these individuals should be called back for testing.

Coordinations: VA, DoD and HHS.

Examining Neuropsychological-Psychological Profiles of Veterans Returning from the Persian Gulf Theater.

Action: VAMC Boston.

Purpose: Conduct a small-scale pilot program examining neuropsychological-psychological profiles of veterans returning from the Persian Gulf Theater.

Coordinations: VA, DoD and HHS.

Environmental Hazards Research Centers.

Action: Three VAMCs (to be determined).

Purpose: A request for proposals to establish up to three, VA-based, research centers for the study of the medical consequences of exposure to environmental and toxic hazards, initially focused on the problems cited by personnel in the PG conflict.

Coordinations: VA, DoD and HHS.

Persian Gulf Interagency Research Coordinating Council.
Action: VA, DoD and HHS.
Purpose: VA, DoD and HHS, make up the newly formed Persian Gulf Interagency Research Coordinating Council. The council, established by the Persian Gulf War Veterans' Health Status Act, will coordinate all research activities undertaken or funded by the Executive Branch of the Federal Government on the health consequences of military service in the Persian Gulf theater of operations during the Persian Gulf War. As an initial step, the council members agreed to organize a conference of experts from within and outside the federal agencies, with a goal of reaching a consensus definition of "Persian Gulf Syndrome."
Coordinations: VA, DoD and HHS.

Persian Gulf Advisory Committee.
Action: VA.
Purpose: A 16 member panel composed of experts in environmental and occupational medicine and related fields from both government and the private sector and representatives from veterans service organizations chartered to address issues related to the diagnosis, treatment and research of PG related health conditions.
Coordinations: VA, DoD and HHS.

Investigation of the Relation Between the Experience of ODS and Post-War Adjustment.
Action: VAMC Clarksburg.
Purpose: Assess difficulties in post-war adjustment among ODS soldiers.
Coordinations: VA, DoD and HHS.

Early Intervention with Appalachian Marine Reservists in ODS.
Action: VAMC Mountain Home, TN.
Purpose: To provide an early intervention debriefing to Marine reservists about the stresses of deployment and combat. Follow-up contacts and tests indicated a high degree of PTSD.
Coordinations: VA, DoD and HHS.

Desert Storm Reunion Survey.
Action: VAMC Boston.
Purpose: Study a broad range of combat and non-combat experiences associated with deployment during ODS. The study will delineate and quantify those experiences and determine their impact on subsequent patterns of adjustment.
Coordinations: VA, DoD and HHS.

Psychological Assessment of Operation Desert Storm Returnees.
Action: VAMC New Orleans.
Purpose: Conduct comprehensive psychological assessments and debriefings of troops mobilized in ODS.
Coordinations: VA, DoD and HHS.

Operation Desert Storm Follow-Up Survey.

Action: VAMC Salt Lake City.

Purpose: A survey designed to elicit VA medical center employees perceptions of ODS activation, deployment, and reintegration experiences.

Coordinations: VA, DoD and HHS.

Psychological Adjustment in ODS Veterans.

Action: VAMC Gainesville.

Purpose: A study of 542 National Guard and Reserve members was conducted with one group being actively involved in ODS and a Control group. Psychological tests were given to determine if differences existed between the service veterans and the control group in terms of overall mental health.

Coordinations: VA, DOD and HHS

Persian Gulf Veterans Coordinating Board

Clinical

DoD Clinical Activities

Persian Gulf Environmental Monitoring Study
Action: U.S. Army Environmental Hygiene Agency
Purpose: To characterize the concentration of environmental pollutants that DoD personnel were exposed to during their stay in the Gulf region.
Coordinations: EPA, VA, CDC, NOAA, NCI, OSHA

Persian Gulf War Industrial Hygiene Evaluation
Action: U.S. Army Environmental Hygiene Agency
Purpose: To monitor and characterize occupational exposures of DoD personnel who had potential high risk exposure to oil fire emissions.
Coordination: Unknown

Persian Gulf War Biologic Surveillance Study
Action: U.S. Army Environmental Hygiene Agency
Purpose: To refine the results obtained from the health risk assessment study.
Coordination: Unknown

Persian Gulf Health Risk Assessment
Action: U.S. Army Environmental Hygiene Agency
Purpose: To assess the health risk from environmental exposures in the Persian Gulf using EPA guidance for Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) sites.
Coordination: EPA,

Illness and Injury Among U.S. Marines during ODS
Action: U.S. Navy Surgeon General
Purpose: To provide information on the magnitude and severity of acute health problems possibly related to the air pollution from the oil fires.
Coordination: none

DoD Persian Gulf War Personnel Registry
Action: U.S. Army and Joint Environmental Support Group
Purpose: To establish a listing of individuals who were deployed to the Persian Gulf during Operation Desert Storm.
Coordination: VA, USAEHA

Combat Unit Tracking Data Base
Action: U.S. Army and Joint Environmental Support Group
Purpose: To establish a listing of units deployed to the Persian Gulf and their geographic locations during Operation Desert Storm.
Coordination: VA, USAEHA

Environmental Hazard Exposure Model
Action: U.S. Army Environmental Hygiene Agency
Purpose: To provide information on estimated pollution levels on numerous dates and locations throughout the Desert Storm Theater of Operations.
Coordination: VA, NOAA

Leishmaniasis - Clinical Evaluation
Action: Walter Reed AMC
Purpose: To evaluate individuals who were manifesting symptoms compatible with parasitic infection by Leishmania species.
Coordination: WRAIR, CDC

Illness Cluster Investigation - 123rd ARCOM
Action: Army Medical Department
Purpose: To investigate an outbreak of illnesses among members of the 123rd Army Reserve Command in Indiana
Coordination: unknown

Persian Gulf Environmental Industrial Exposures
Action: U.S. Army Environmental Hygiene Agency and the U.S. Navy
Purpose: To attempt to characterize the potential industrial sources for environmental hazards in the Persian Gulf region.
Coordination: unknown

Illness Cluster Investigation - 24th Naval Reserve CB
Action: Navy Environmental Preventive Medicine Unit - 2
Purpose: To investigate an outbreak of illnesses among members of the 24th Naval Reserve Construction Battalion in Georgia and North Carolina
Coordination: USAEHA, DIA

Persian Gulf Veterans Coordinating Board

Clinical

VA Clinical Activities

Persian Gulf Registry.

Action: VACO.

Purpose: Establish a special record (mandated by P.L. 102-585) listing certain individuals who served in the PGW. Registry listings total over 127,000. About 11,000 Registry health exams have been completed.

Coordination: VA, DoD and HHS.

Persian Gulf Referral Centers.

Action: VAMCs - D.C., West L.A., and Houston.

Purpose: Establish three centers at VA medical centers to handle cases of unusual symptoms in PG veterans whose evaluation at a local VA medical center has evaded diagnosis. Fifty-three veterans have been treated and discharged.

Coordinations: VA, DoD and HHS.

Family Support Program.

Action: VA.

Purpose: Provide marriage or family counseling for PG veterans their spouses and children. Over sixty three thousand veterans have been reached through outreach activities, with 12,608 receiving individual, group, or marriage and family counseling.

Coordinations: VA, DoD and HHS.

Readjustment Counseling Service.

Action: VAMCs.

Purpose: To ease Gulf theater veterans transition to civilian life and gain assistance in such areas as benefit questions, substance abuse, marriage counseling, employment, and PTSD. About 40,000 Gulf theater veterans have been seen to date.

Coordinations: VA, DoD and HHS.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

April 6, 1994

Chairman Lane Evans
Subcommittee on Oversight
and Investigations
House Committee on Veterans Affairs
U.S. House of Representatives
Washington, D.C. 21515

Dear Chairman Evans:

Please find below the VFW's responses to your post-hearing questions of the Oversight and Investigations Subcommittee hearing on November 16, 1993 regarding health care problems and the concerns of Persian Gulf War veterans. It is my pleasure to provide you with this information.

1. What problems are Gulf War veterans still having getting health care from VA?

RESPONSE: A number of veterans report that there are still VA medical centers who do not seem to be aware that Persian Gulf veterans are now authorized priority health care under law. Further, while certain VAMCs seem to be aware of PL 103-210, they are slow and uncertain as to how to go about answering its mandates. Some VAMCs are billing insurance companies for care provided to Persian Gulf veterans. As it now stands, if the veteran fails to file for service-connection with VA for a Persian Gulf disability, he is subject to a co-payment based on income. Insurers are then billed.

2. Are VA staff knowledgeable about the Registry program and what problems are veterans having with VA's Registry program?

RESPONSE: The awareness about the Registry Program would still seem to be uneven throughout the VA system. When a Persian Gulf veteran goes to a VAMC or a VARO for assistance, he or she should be informed about the existence of the Registry. This is not always the case. VA should also conduct much more aggressive outreach so that Persian Gulf veterans who do not go to VA for a given service will nonetheless learn about the existence of the program.

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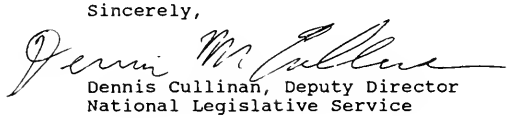
3. Are most Gulf veterans, including service members still on active duty and reservists, aware of VA's Registry program?

RESPONSE: As indicated in response #2, VA and DOD need to be much more active in advising Persian Gulf veterans about the existence of the Registry Program.

4. What special problems are Persian Gulf War veterans having with VA claims adjudication?

RESPONSE: The main complaint would seem to be the length of time it takes to process such claims. Also given that there is currently no definitive "case definition" for Persian Gulf Syndrome, VA lacks the guidelines to appropriately respond to veterans claims' for compensation for their Persian Gulf related disabilities.

Sincerely,



Dennis Cullinan, Deputy Director
National Legislative Service

Congressman Lane Evans
36 Cannon House
Washington,DC.20515-6335

Jan 2-26-94

Dear Congressman Evans, First I wish to apologize for the delay in reply to your letter dated Dec. 1,1993. We were hoping to be able to give you significant information about toxins but Dr. Mirocha at the University of Minnesota had to order new equipment in order to perform the tests for mycotoxins and as yet, the tests have not been completed.

Let me address the second question,first:"What problems are gulf veterans still having getting treatment from V.A.?
My understanding from talking to many veterans and their spouses is that there are long waits to get on the registry,many doctors seem uninterested and many hospitals are doing little or no testing outside of the original protocol of CBC, Profile 8, urinalysis and chest x ray. Treatment for symptoms from the gulf,diarrhea,rash, shortness of breath, fatigue,memory problems has been unsuccessful and therefore people still have their same problems.

Question three:"What else should the V.A. be doing to identify the cause(s) of the Gulf veterans health problems."
In my opinion, we need the broad based testing that was suggested in the 9-9-93 recommendations of the staff report to Senator Riegle regarding viral, fungal, DNA studies, Bacterial and toxin studies. We have been in contact with such a Lab-Dr.Andresen of the Lawrence Livermore Forensic Sciences Lab in Livermore California. The central problem is that this broad based testing cost $3500-$5000 per person and the DVA hospital in Tuskegee cannot afford do the test(s). We are in contact with many people with various types of problems from various regions of the Gulf. It would be appropriate to take 10 or 20 of these people and test them with the complete battery of test available.

Question one"What direct evidence supports your conclusion that U.S. Troops were subjected to toxin." At present we have no direct, positive Laboratory test. You may know however that the diagnosis of exposure to toxins(clinical diagnosis) is based upon "History", symptoms-memory problems, trouble sleeping, muscle twitching, personality changes and cholinesterase levels. There are many "histories" of alarms going off, positive test from FOX vehicles, testimony of veterans hit with blister agents,etc. The symptoms are common. We are testing for cholinesterase levels now. We cannot answer as to the altering of agents. The Riegle statement proves that they had the agents.

Question four:"What changes should be made in the persian gulf protocol." Since we have fou d an unexpected pervelance of evelations in immune globulins and hepatitis tests, SEd rate, Hepatitis profle A and B and Immunoelectrophoresis should be added to the protocol.

Finally I wish to reiterate the need for funds for testing. The Lawrence livermore Lab is highly regarded by the Pentagon and Congress. Testing is expensive. Only 20 people need to be used as a test group. We feel that the evidence presented to your committee over the last year has shown that this testing is indicated.

Sincerely

Jackson

C. Jackson M.D.
Environmental Physician
DVA Hosp Tuskegee,ALA.

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